North Carolina
Regional Community Child Protection Teams
[Citizen Review Panels]
2007 Annual Report

Prepared by
The North Carolina Child Fatality Prevention Team

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Credits and Acknowledgements

Credits

The development of the **2007 Annual Report** required contributions and input from a number of volunteers who gave freely of their time and talents in an effort to strengthen the child welfare system in North Carolina. The effort was lead by a core group of contributors on both the state and local levels. Thank you to the following contributors:

Regional Reports:

The 2007 Annual Report would not be possible without the work of the CCPT Regional Teams. Each regional team was charged with completing an end-of-year report. The following are members of Regional Teams[1], who participated in the development of a regional report:

Region I

- Andrew Payne- Wilson County DSS
- Carol Cobb- Edgecombe County Public Schools
- Christy Nash- Wilson County DSS
- Debbie Cook- Nash County DSS
- Eva Rogers- Nash County Guardian Ad Litem
- Gloria Braddy- Bertie County DSS
- James Yates- Chowan County Citizen
- Jeff Mitchell- Dare County EMS
- Kay Overton- Washington County Partnership for Children, Inc.
- Linda Roberts- Mid-East Commission, Beaufort County
- Mary Jo VanHorne- Franklin County Guardian Ad Litem
- Melissa Ferrell- Currituck County DSS
- Michele Braswell- Halifax County DSS (Co-Leader)
- Pandora College- Citizen Rep- Tyrell County
- Sara Lane- Camden County DSS
- Susan Davenport- Martin County DSS
- Terry Bell- Northampton County Guardian Ad Litem (Team Leader)
- Midge Hudyma- School Social Worker- Pasquotank High School

Region III

- Anne Laukatitis-Cabarrus County Partnership for Children
- Cindy Hendricks- Domestic Violence Services in Davie County
- Wilma Laney- Moore County DSS Board Member
- Kathy Hitchcock- Davidson County DSS (Team Leader)
- Mary O'Neal Mauney- Union County DSS
- Sharon Scott- Stanly County DSS
- Elizabeth Blair- Rowan County Citizen
- Alice Lammonds- Montgomery County DSS

Region IV

- Robin Testerman-Children's Center of Surry (Co-Leader)
- Linda Devine- Stokes County Guardian Ad Litem (Co-Leader)
- Betty McGurk- Surry County Citizen

[1] Region II did not submit an End-of-Year Report

- Amanda Reeves- Rockingham County Guardian Ad Litem
- Joan Corio- Children's Center of Surry
- Nanci Shannon- Ashe County Schools
- Diane Rocker-Orange County Schools
- Carmen Coley- Child Victim Services of Chatham County
- Tim Murphy-Wilks County Child Abuse Prevention Team
- Hillary Carroll- Burlington Pediatrics
- Callie McBroom- Alamance County DSS
- George Bryan- The Children's Home
- Ken Richardson-Regional Member[2]
- Tonia Goad-Regional Member
- Erin Eskridge-Regional Member
- Tammy Chaney-Regional Member
- Cathy Waugh-Regional Member
- Lee Cornett- Regional Member
- Hillary Carroll-Regional Member

Region V

- Cathy Brooks-Polk and Rutherford County Smart Start (Team Leader)
- Alisa Ashe- Macon County KIDS Place
- Vanessa Henley- Avery County
- Kelly Icenhour- Avery County DSS
- John Lewis- Madison County Guardian Ad Litem
- Lou Parton- Polk County DSS
- Kathie Williams- The Children's Center of Transylvania County

Region VI-A

- Carol McConnell- Catawba Citizen/Parent (Co-Leader)
- Lenora Campbell- WSSU Grandparenting Program (Co-Leader)
- Pamela Brooks- Catawba County DSS
- Lisa Alexander- Guilford County Health Department
- Cynthia Napoleon-Hanger- Exchange/SCAN
- Cathie Beatty- Buncombe County DSS
- Sally Bradshaw- Regional Member

Region VI-B Members Participating in the Development of the Report:

- Heather Skeens- Cumberland County DSS (Co-Leader)
- Loretta Keelin- Onslow County DSS (Co-Leader)
- Katie Lemaire-New Hanover County Citizen
- Julie Rawls- Pitt County DSS
- Joan Dramis- Wake County Human Services
- Liz Kachris-Jones- New Hanover Guardian Ad Litem
- Gina Bustle- Safe Child

The State Annual Report:

The North Carolina State Child Fatality Prevention Team subcommittee who prepared the Annual Report included: Al Dietch, Brenda Edwards, Susan Robinson, Krista Ragan, and Selena Childs. Special thanks to State Team member Catherine Joyner, who led the subcommittee and Chanitta Deloatch a MSW/MPA candidate and child welfare

[2] "Regional Member"- Agency affiliation was not provided

scholar from UNC-CH interning with the NC Child Maltreatment Prevention Leadership Team through the Department of Administration- Youth Advocacy and Involvement Office State Government Summer Internship Program. As a part of her internship, Chanitta Deloatch made contact with local teams, checked facts and drafted summaries. In addition, a special thanks to Kendra Rocha of the NC Division of Public Health; the Women's and Children's Health Section, for her assistance with editing this report. This report could not have been completed without the dedicated service of the NC Child Fatality Prevention Team.

Acknowledgements

CCPTs are only effective with the help and support of the local county's Department of Social Services agency personnel. The State Child Fatality Prevention Team and the Regional Teams would like to acknowledge and thank the representatives of the county Departments of Social Services for their work on the CCPT and assistance with the development of the regional reports.

The State Child Fatality Prevention Team and the Regional Teams wish to acknowledge the North Carolina Division of Social Services for their continuing work with the CCPTS and development of the Regional Community Child Protection Teams.

Introduction

Protection of North Carolina's children is not the sole responsibility of a single agency. The phrase "It takes a village"[3] embodies the philosophy that all citizens are responsible for the health, safety, and well being of North Carolina's children. Recognizing this need for collaboration, in 1991, the State of North Carolina instituted the North Carolina Child Fatality Prevention System[4]. One branch in this 4-pronged system is the Community Child Protection Team (CCPTs), created to ensure community involvement in the child welfare process. CCPTs are located in each of North Carolina's 100 counties and serve to examine the effectiveness of child welfare programs and recommend improvements to child protective services.

In 1996, the federal government amended the Child Abuse Prevention and Treatment Act (CAPTA)[5]. The amendment mandated that state's receiving federal funds under CAPTA create at least three Citizen Review Panels' (CRPs) by July of 1999. The federal statute requires that CRPs evaluate the extent to which the state and local agencies are effectively discharging their child protection responsibilities. As Congress did not prescribe a standard composition, the structure of CRP's varies from state to state. As North Carolina had a pre-established system through the CCPT, the state elected to work within that structure to comply with the 1996 CAPTA amendment. Therefore, ***CCPT/CRP*** will be used throughout the remainder of the document to refer to the Citizen Review Panels' required by CAPTA.

In an effort to enhance the CCPT/CRP program, the NC Division of Social Services developed a "regional team" approach in 2007, with a goal of improving the outcomes for children and families in North Carolina. The Regional process for CCPT/CPR began in 2008. Previously, each of the 100 CCPTs submitted reports to the Division of Social Services (NC DSS), which compiled results and completed the required Annual Report for North Carolina. In January 2008, Regional Community Child Protection Teams were formed and charged with completing an End-of-Year Report for their region. The Regional Teams used information from the local county CCPTs to develop a consensus on child welfare issues that should be included in the regional End-of-Year Report. Additionally, the Regional CCPTs should arrange community forums to discover the child welfare needs and concerns of citizens in their regions and address child welfare issues of statewide concern. At the request of NC-DSS, the State Child Fatality Prevention Team agreed to complete North Carolina's Annual Report based on the Regional Team Reports. The 2007 Annual Report is the first report issued under the new regional structure in North Carolina.

[3] an African proverb
[4] An overview of the NC Child Protection System is provided on pages 6-7
[5] Child Welfare Information Gateway

Federal Legislation

Child Abuse Prevention and Treatment Act (CAPTA)[6]

The Child Abuse Prevention and Treatment Act was enacted in 1974 to provide grant funds to states to support child protective services and community-based prevention services, as well as research, training, data collection, and program evaluation. CAPTA requires states receiving grant funds to establish at least three citizen review panels, *composed of volunteer members who are broadly representative of their community, including members who have expertise in the prevention and treatment of child abuse and neglect.* Each Citizen Review Panel must meet at least once every three months and evaluate the extent to which the state is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan. In addition, Citizen Review Panels are required to review child fatalities and near-fatalities and examine other criteria important to ensure the protection of children, such as the extent to which the state child protective services system is coordinated with the foster care and adoption programs established under Title IV-E of the Social Security Act. Section 106(d) of CAPTA requires that the citizen review panels develop annual reports and make them available to the public. These reports must be completed no later than December 31 of each year and should, at a minimum, contain a summary of the panel's activities, as well as the recommendations of the panel bases upon its activities and findings.

The Keeping Children and Families safe Act of 2003 amended CAPTA to include the following requirements:

- Each Citizen Review Panel must examine the practices (in addition to policies and procedures) of the state and local child welfare agencies.
- Citizen Review Panels must provide public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community.
- Each CRP must make recommendations to the state and public on improving the child protective services system.
- The appropriate state agency is required to respond in writing no later than six months after the CRP recommendations are submitted. The state agency's response must include a description of whether and/or how the state will incorporate the recommendations of the CRP (when appropriate) to make measurable progress in improving the state child protective services system[7].

[6] ABA Center on Children and the Law
[7] section 106(c)(4)(B)(i) of CAPTA

The Child Fatality Prevention System in North Carolina

In 1991, a series of child abuse fatalities, in addition to a high infant morality rate, and other preventable child deaths prompted the state of North Carolina to create a program that would assist in determining how to prevent childhood deaths. The result was the North Carolina *Child Fatality Prevention System,* established under Article 14 of the Juvenile Code, NC General Statute 7B-1400-1414. The goals of this System are:

- developing a community approach to the prevention of child abuse and neglect,
- understanding and reporting the causes of child deaths,
- identifying gaps in services to children and families, and
- making and carrying out recommendations for changes to laws, rules, and policies to prevent future child deaths, especially those from abuse and neglect [8]

There are four components to the North Carolina *Child Fatality Prevention System*: the North Carolina Child Fatality Task Force (CFTF), the State Child Fatality Prevention Team ("State Team"), the Local Child Fatality Prevention Teams (CFPTs) and the Community Child Protection Teams.

1. **The North Carolina Child Fatality Task Force** (**CFTF**, "**Task Force**") is the public policy arm of the child fatality prevention system charged by statute with making recommendations to the General Assembly regarding laws, and policies that will lead to the prevention of child deaths as well as to promote the safety and well-being of North Carolina's children. [9] The CFTF is a 35-member legislative study commission, with appointees including legislators and multi-agency membership. The Task Force has three working committees which study issues related to perinatal health, intentional deaths, and unintentional deaths. As needed, subcommittees are formed to work on specific issues that require in-depth analysis.

2. **State Child Fatality Prevention Team ("State Team")**. The State Team is a multi-disciplinary group charged by statute with reviewing all deaths of children under 18 years that are investigated by the NC Medical Examiner system with particular focus on those suspected to be the result of abuse or neglect to prevent future deaths by identifying gaps in systems, policies, and laws that may have contributed to child deaths. The State Team receives recommendations from the Local CFPTs and the CCPTs, as well as creates their own recommendations that are then sent for the consideration of the Child Fatality Task Force for improvements and possible solutions to prevent future child fatalities.[10] In addition, the State Team serves as a data source for the state of North Carolina and provides training for agencies that are involved with child well-being. The State Team staff are housed within the Office of the Chief Medical Examiner (part of the Division of Public Health).

3. **Local Child Fatality Prevention Teams (CFPT**) are located in all 100 NC counties, and are charged by statute with *reviewing child deaths that are not related to child abuse and neglect*. Based on their review, the CFPTs recommend actions to be taken on the local, state and legislative level to prevent other child fatalities. This information is provided to

[8] Vitaglione, 2004
[9] Ibid; Jordan Institute for Families, 2001
[10] Ibid

the local board of county commissioners and to the local board of health. The state-level coordinator of the CFPTs is housed in the Division of Public Health.

4. **Community Child Protection Teams (CCPT)** program is the 4th component of the North Carolina *Child Fatality Prevention System*. As this report is a product of the CCPT program, a more detailed description of the CCPT is provided in the following section.

To avoid duplication, counties were given the option of combining the local CFPT and CCPT or operating them separately. The majority of counties are combining these two teams. [11]

In addition to the work of the groups comprising the NC child fatality prevention system, the NC Division of Social Services conducts intensive reviews of child fatalities when there was suspicion of abuse or neglect involved in the child's death and when the child had a record with child protective services within the past twelve months. The intensive reviews are designed to identify system changes needed to improve services to families. [12]

[11] *Vitaglione, 2004, and Jordan Institute for Families, 2001*
[12] *Vitaglione, 2004, and Jordan Institute for Families, 2001*

North Carolina Community Child Protection Teams / Citizen Review Panels'

Background

The Community Child Protection Team (CCPT) program was established as one means for the state and local communities to form a partnership to strengthen child protection in North Carolina. CCPTs were established in May of 1991 by an Executive Order. The duties and responsibilities of the CCPTs were adopted in North Carolina Administrative Code 41I .0400. The original purpose and composition of the team was further formalized and expanded by G.S. 7B 1406, effective July 1, 1993. To meet federal requirements, CCPTs were designated as Citizen Review Panels' in 1997.

Mission

The mission of the North Carolina Community Child Protection Teams (CCPT) is to improve the safety, well being and permanency of North Carolina children by examining the practices, policies and procedures of state and local practices. With that aim in mind, CCPTs evaluate the extent to which state and local agenices are effectively meeting their child protection responsibilities, and make recommendations for systemic changes which will strengthen North Carolina families and over-all child well being.

The mission of the Community Child Protection Team (CCPT) is accomplished through building a constituency for child welfare and protection issues and soliciting public comment to assess the impact of the policies and practices of North Carolina's child welfare system on children and families. Annually, each county team reports to the Board of County Commissioners on the status of child well being in the county. Additionally, a Regional CCPT, composed of members from the county CCPTs prepares an annual report of its findings and recommendations to the state for improvements in the North Carolina child welfare system.

Mandate

The mandate of the Community Child Protection Teams (CCPT) is to "evaluate the extent to which the agencies (state and local) are effectively discharging their child protection responsibilities."[13] The CPPTs must examine policies, procedures, and where appropriate, specific cases handled by the state and local agencies providing child protective services. The CCPTs are also to evaluate the extent to which the agencies (state and local) are effectively discharging their child protection responsibilities in accordance with the state's CAPTA plan, child protection standards, and any other criteria that the members consider important to ensure the protection of children. This may include a review of how well the child protective service program is coordinated with foster care and adoption programs and a review of child fatalities and near fatalities.[14]

Location and Organization

Community Child Protection Teams, located in all 100 counties, are interdisciplinary groups made up of community representatives who meet to promote a community-based approach to the problem of child abuse and neglect. The CCPTs review active CPS cases and child fatalities when the deceased child or the child's family received child welfare services within twelve months prior to the child's death and the death was suspected to have been caused by abuse or neglect. Based on their review, the CCPT recommends actions the community should

13 CAPTA, 1996

14 CAPTA, 1996

take to fill in gaps in community services or resources that may prevent other child abuse and neglect fatalities.

The composition of the Community Child Protection Team is diverse. CCPTs consist of representatives from community agencies and organizations as well as citizens-at-large. NC law mandates membership of certain agencies and organizations. The mandated members includes: *The county director of social services and a member of the director's staff, a local law enforcement officer, an attorney from the district attorney's office, the executive director of the local community action agency, the superintendent of each local school administrative unit; a member of the county board of social services, a local mental health professional, the local guardian ad litem coordinator, or the coordinator's designee; the director of the department of public health; and a local health care provider.* The board of county commissioners may appoint a maximum of five additional members to represent various county agencies and the community-at-large to serve on any local team. [15]

Regionalization

As mentioned previously, CCPTs were determined to fit the requirements of the CAPTA Citizen Review Panels (CRPs) in 1997. Based on guidance from the Department of Health and Human Services- Administration for Children and Families (DHHS-ACF) the North Carolina Division of Social Services established a new regional CCPT system which will serve as the enhanced structure for Citizen Review Panels (CRP) to meet CAPTA requirements. While the 100 local CCPTs continue to serve as CRPs[16] for North Carolina- seven - (7) regional teams[17] were established in January 2008. The county assignment in a Regional Team is based on geographical location[18].

The intent of the regional team approach is to strengthen the CCPT process by adding "strength of numbers" as each regional team's membership is intended to include a member from each county CCPT[19]. Regional teams take information from local teams and develop that information into recommendations to the state. Therefore, rather than a single county team making a recommendation, a regional team, comprised of membership which varies from 6 to 21[20] county teams, make recommendations. Appendix B lists the county composition for each regional CCPT.

Community Child Protect Team Coordinator's Activities

The Community Child Protection Team (CCPT) Coordinator position is housed at the NC Department of Health and Human Services (NC-DHHS) within the Division of Social Services (DSS). The CCPT Coordinator's role includes providing training and technical assistance to all 100 local Community Child Protection Teams, as well as conducting site visits, and serving as a liaison between the Division of Social Services and local CCPTs.

From July-November 2007, the CCPT Coordinator developed North Carolina's CCPT Regional Plan which included writing the policy, meeting with the Director's Association and Children's Services Committee, reviewing the regional plans of other states, and forming a work group to

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[15] *NC-DSS Policy on Community Child Protection Teams*
[16] For CAPTA requirements
[17] Regional Teams are representative of all 100 counties
[18] Urban counties are jointly grouped
[19] Actual membership does not represent every county in all regional teams
[20] Urban counties have less representation by number of counties represented but equal citizen participant by county demographics

provide input into the process. During the development of the CPPT Regional Plan, the CCPT Coordinator also met with the North Carolina State Fatality Prevention Team for engagement in the enhanced CCPT process. At the end of 2007, the CCPT Coordinator distributed the CCPT Regional Plan and prepared training materials to be utilized for plan implementation. Additionally, the CCPT Coordinator also developed a CCPT End of Year Survey.

In January 2008, the CCPT Coordinator conducted Regional CCPT training at four sites state wide for the newly formed Regional CCPTs and received local CCPT end of year reports. In February 2008, the CCPT Coordinator met with the seven- (7) newly formed Regional CCPTs to distribute the end of year reports and to assist each team in selecting members to serve as team leaders, co-leaders, recorders, etc.

Throughout 2008, the CCPT Coordinator maintained contact with each Regional Team through team leaders, presented Regional Reports to the NC State Fatality Prevention Team, presented a workshop about the state's new CCPT Plan at the National Citizen Review Panel Conference in St. Paul, Minnesota, and is in the process of developing a community needs assessment in conjunction with Regional CCPT members. Furthermore, the CCPT Coordinator conducted 5 CCPT chairperson trainings and completed 10 site visits to local CCPT meetings.[21]

[21] Provided by the NC-DSS CCPT Coordinator

Future Directions
2007 Regional Team Recommendations

Overview

Six of the seven regional Community Child Protection Teams submitted end-of-year reports. Regional Teams were asked to state the need or problem within their region, state the desired outcome and provide recommendations. The Child Fatality Prevention Team was charged with completing the 2007 Annual Report. A subcommittee of the Child Fatality Prevention Team reviewed each of the regional reports, sought clarification from the regional teams (when possible), as well as reviewed relevant legislation and requirements for Citizen Review Panels and received technical assistance from the University of Kentucky. The subcommittee began looking for common themes in individual reports in an attempt to consolidate individual regional reports into a fluid annual report while maintaining individuality and uniqueness of each the regions strengths, needs and recommendations. The full report for each regional CCPT is located in Appendix A**.**

Not surprisingly, many of the recommendations of the Regional CCPTs mirrored some findings of the 2007 ACF Family Child and Family Services Review (CFSR) including need for increased service array (including mental health and domestic violence services), and increased permanency outcomes. Recommendations of the Regional CCPTs fell into the following themes:

- Mental Health: Improved access to services.
- Domestic Violence: Improved access to services.
- Child Abuse and Neglect (CAN) Reporting: Improved education on recognition and reporting of CAN by mandated reporters; including medical providers, teachers and child care providers.
- Improved access to substitute (foster care) placements within the child's community.
- Improved permanency outcomes for children within the child welfare system- including improvements in the court system and options for custody and/or guardianship payments.
- Service array improvement:
  - Evidence-based family strengthening programs;
  - Prevention program;
  - Day Care;
  - Transportation; and
  - Services for the Hispanic community and undocumented residents.
- Improved services or "best practice principles" for a variety of public agencies.

These themes are outlined in more detail in the following recommendations. When recommendations were not clear, an attempt was made to ascertain the meaning of the recommendation. To review the full text of recommendations, a copy of each regional report that was utilized in creating these recommendations can be found in Appendix A.

Recommendation 1

Mental Health Services

Need:
The NC mental health system is in "system reform". Not surprisingly, 100% of the CCPT/CRP regional teams reporting (n =6) representing 84 counties made recommendations regarding the need for improved mental health and substance abuse services. The need or problem stated was inconsistent, unobtainable and unavailable appropriate and affordable mental health and substance abuse resources for children and adults due to mental health reform. Additionally, the current mental health/substance abuse system was cited as difficult to understand, access, and navigate.

Outcome:
The desired outcome is for every North Carolina citizen to have timely access to appropriate, effective and affordable mental health and substance abuse treatment through strategically focused services provided by qualified and competent providers. The following represents recommendations from the regional teams. These recommendations are broken out by the following categories: general, funding, provider, local, and Local Management Entities issues.

Recommendations:[22]

General:

- To meet the consumer's needs, mental health services should return to the one stop for assessment, treatment, inpatient and out patient therapy and medication management.

- The state should ensure that each county (or within a reasonable distance of the county) provides specialized treatment services such as those for domestic violence offenders, domestic violence victims, substance abuse offenders, sexual abuse offenders, victims of sexual abuse, psychiatric specialties, etc. These services should be identified, and placed on an updated website for easy accessibility.

- State [North Carolina] to further reform the mental health system so that children and families within the community can receive affordable and effective treatment for substance abuse, sexual offender treatment for teens, domestic violence victims, and treatment for children who have been abused or neglected.

- Stabilize [the] Mental Health System.

- Examine Catawba County model-integrating the MH/SA/DV; Research and model Catawba County.

[22]Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

- Increased Substance Abuse Programs to address:
  - Prescription Drug Abuse
  - Teen Substance Abuse (including prescription and OTC).

- Oversight and report on the quality and services provided to the community, i.e. a Report Card on the mental health system.

- Revise the "service definitions" so clients can get more adequate multiple services from the provider when needed.

- Develop and follow MOU/MOAs established with the Department of Social Services, Law Enforcement, Department of Defense, Mental Health, local school system for consistent collaboration.

- Increase availability of home based treatment services that are aware of child maltreatment, MH/DD/SAS.

- Increase substance abuse programs to address: prescription drug abuse and identify needs to address teen substance abuse (including prescription and OTC).

Funding:

- Insure funding for outpatient and inpatient treatment for women with children who have substance abuse problems.

- Broaden the service definitions to include a provider's training and experience so that providers are receiving adequate payment to help reduce the turnover in providers.

- Allocate adequate funding to meet the Mental Health and Substance Abuse issues.

- Address care issues that may result from lack of insurance (Mental Health Case uninsured)

Providers:

- Current mental health providers are in need of more supervision and oversight from the state to ensure effective services are being provided to clients.

- Increase [the number of] qualified mental health providers; increase the number of licensed psychiatrists.

- Expand recruitment of trained, experienced providers and fund incentives to retain good providers.

- Credentialed substance abuse professionals willing to provide outpatient treatment.

Local:

- Counties should review local services and identify any barriers to those services.

- Counties should examine effective models already in place (i.e.- Catawba county).

- Counties must have a method of notifying all agencies with contact numbers for after-hours personnel and phone numbers, when they provide after hours services. This information must be kept current.

- Training and review of any updates should be disseminated to all agencies and their staff. Each agency will be responsible for notifying CCPT of updates or changes to best practice policy

Local Management Entities (LME):

- More effective Local Management Entities.

- LME's need more authority on case decisions. They have first hand knowledge from local providers and community agencies working together through System of Care.

- Training and review of any updates should be disseminated to all agencies and their staff. Each agency will be responsible for notifying CCPT of updates or changes to best practice policy.

- Counties [LMEs] must have a method of notifying all agencies with contact numbers for after-hours personnel and phone numbers, when they provide after hours services. This information must be kept current.

Recommendation 2[23]

Domestic Violence Services

Need:

Domestic violence is a serious public health issue affecting millions of women and children nationally.[24] Three (3) out of six (6) of the regional CCPT/CRP teams reporting, representing 41 counties, cited the lack of domestic violence services as a need in North Carolina. A lack of domestic violence services was noted as an area of need in the North Carolina Child and Family Services Review. The need or problem was stated a lack of affordable, accessible, and effective services for families experiencing or surviving domestic or family violence. In addition, the lack of specialized treatment for domestic violence offenders was also stated as a need.

Outcome:

The desired outcome is improved access to domestic violence services that are consistent from county-to county, affordable, comprehensive effective for all children and families experiencing or recovering from domestic violence. The regional CCPT/CRPs not only

[23] Regional CCPT recommendations included DV recommendations within the Mental Health Recommendation- the **State Team**, subcommittee broke out MH/DD/SAS recommendations from DV recommendations. Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

[24] US DHHS (2003); Kate B. Reynolds Charitable Trust (2003)

recommended services for victims and survivors that are evidence-based and holistic, but also recommended services that are preventive, beneficial for perpetrators, as well as for children who witness domestic violence.

Recommendations:[25]

- Evidence-based [Domestic Violence] programs.
- [Domestic Violence] Programs that address entire family needs.
- [Domestic Violence] Perpetrator treatment.
- [Services for] Children witnessing domestic violence and [exhibit symptoms of] Post Traumatic Stress Syndrome.
- Improve access to services that are affordable and effective.
- County model-integrating the MH/SA/DV. (Research and Model Catawba Co.).

Recommendation 3

Recognizing and Reporting Child Abuse and Neglect

Need:
Child abuse and neglect continues to be an epidemic public health issue in the United States. In 2006, more than 5 million children were reported to child protective services (CPS) as alleged victims of child maltreatment nationally; while in North Carolina more than 111,000 children were assessed for maltreatment. Although these numbers are staggering, researchers agree that the numbers of reports are an under-representation of the actual numbers of children who experience child maltreatment. [26] CPS can only respond to the children who are actually reported as suspected victims of child maltreatment. The need or problem cited by the regional CCPT/CRP was a lack of awareness and knowledge of mandatory reporting laws as well as a lack of knowledge of what constitutes child maltreatment. Three (3) of the six (6) reporting regional CCPT/CRPs cited this as a need.

Outcome:
The desired outcome is statewide community awareness and education surrounding mandatory reporting laws, child maltreatment, and available services/resources for all mandated reporters with a special emphasis on the medical and educational settings. Teams not only acknowledge the need for community education, in general, but they also specified the benefit of child maltreatment identification training for medical, law enforcement educational personnel.

[25] Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.
[26] IOM New Directions for North Carolina (2005)

Recommendations:[27]

- Statewide community awareness of mandatory reporting laws and services provided by DSS and within the community, and how to report child abuse and neglect.

- There is a lack of understanding about mandatory reporting laws with law enforcement and school systems do not make reports due to their lack of knowledge about "whether or not something should be done."

- Funding and partnering with other agencies (Prevent Child Abuse) for trainings and seminars locally for medical personnel to increase their knowledge of child maltreatment. CCPT will help disseminate training information on such trainings.

- Encourage incentives for physicians who participate in the Child Medical Examiners program for both the initial and ongoing training.

Recommendation 4

Permanency

Need:
All children deserve the right to grow up in a secure, loving, and nurturing environment where he or she can learn, thrive, and flourish. According to the NC Division of Social Services, our foster children deserve safe and nurturing homes while in substitute care as well as deserve safe, nurturing and **permanent** homes **within one year of initial removal from their homes**.
Four (4) out of the six (6) reporting regional CCPT/CRPs, representing 62 counties, cited the inability to achieve permanency for all children in the public child welfare system within one year as a need.

Outcome:
Achieve permanency for all children in the public child welfare system within one year of initial removal is the desired outcome. Making juvenile court a priority, removing financial barriers to children receiving permanency through funding custody and guardianship, as well to support kinship care at a level that enhances ability to provide quality care and permanency are just a few recommendations from the region CCPT/CRPs in which this need can be met. Several CCPTs stressed the importance of training judges, attorneys, and other judicial staff on the impact that delayed permanency can have on a child. The following recommendations were made to strengthen efforts in achieving permanency for children within the North Carolina child welfare system.

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[27]Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

Recommendations:[28]

- TPR filing and completions are timely within ASFA guidelines. [29]
- Training for judges and attorneys on awareness and impact of judicial delays in relation to child permanency.
- Need exists for a protocol to put in place in which Chief Judges are notified of delays and a plan to be developed to address delays.
- For social workers to have better access to National Criminal Record checks. Social workers to become DCI trained in order to complete National Criminal Record checks.
- Remove financial barriers to children achieving permanency through custody and guardianship agreements by reallocating foster care dollars currently being paid to maintain placements for children until they age out of foster care.
- Use the money [foster care board payments] to pay for subsided custody and guardianship agreements to provide financial support for children for whom reunification is no longer the goal but termination of parental is not in the best interest of the child, and custody and guardianship offers the best and only chance for achieving permanency instead of having children age-out of the foster care system.
- Develop a collaboration with law schools to do cross training for Judges and Attorneys on the different disciplines they'll be working with in Child Welfare cases and the developmental and mental health needs of the child.
- Make juvenile court a priority and have better coordination of non-conflicting court dates across county lines within a judicial district (same attorneys are serving adjoining counties and are often scheduled to be in court in more than one county at the same time)[30].
- Fund supportive services for kinship care at a level that enhances ability to provide quality care and permanency.

[28] Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.
[29] Listed as an outcome in the regional report but also serves as a recommendation
[30] Listed as an outcome in the regional report but also serves as a recommendation

Recommendation 5

Community Foster Care Placement Resources

Need:
Thousands of children in North Carolina, from infancy to adolescents, reside in the foster care system each year. Therefore adequate foster care placements, within the child's own community, are an essential component of the child welfare system. The need, as cited by the CCPT/CRPs is inadequate out-of-home placements available within local communities that meet the needs of the children in need of substitute care. Four (4) out of the state's six (6) reporting regional CCPT/CRPs representing 52 counties, identified the need for more foster care placements resources within local communities.

Outcome:
The desired outcome is adequate and accessible foster care placements available to keep children within their respective communities when out-of-home placement is deemed necessary.

Recommendations: [31]

- Children's Home Society will certify and DSS can license if no MAPP trainer is in the county. [Formalized public-private partnerships to recruit, train, and license an adequate number of foster and adoptive homes].

- [There are not adequate MAPP-GPS certified facilitators in local communities.] Local DSS to be informed of train the trainer classes [for MAPP-GPS].

- Fully fund positions in local DSS agencies for foster care recruitment, licensing, and additional follow-up training.

- Reduce the recommended case load for foster care licensing social workers.

- Develop more higher level therapeutic placement opportunities in the state.

- Dedicate more State DSS staff to process foster care home licensing applications.

- Increase efforts to recruit, train, and support caregivers who have ability and skills with increased funding from the state.

- Fund supportive services for kinship care at a level that enhances one's ability to provide quality care and permanency.

[31] Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

Note: The following five (5) recommendations relate to service array. These recommendations include: increased need for prevention programs including evidence-based family strengthening education programs; transportation; day care services; and community based services for special populations.

Recommendation 6

Prevention

Need:
Child maltreatment prevention efforts include activities, strategies, or programs to reduce risk factors and increase protective factors associated with child maltreatment. These efforts are designed to increase the capacity of parents, caretakers, and communities to protect, nurture, and promote the healthy development of children. While a number of activities can comprise child maltreatment prevention, activities are typically placed into three categories:

- Universal strategies target activities to the general population with the goal of preventing child maltreatment from ever occurring.
- Selective strategies target activities to a group with specific risk factors with the goal of preventing child maltreatment from occurring in that group.
- Indicated strategies target activities to a group that has experienced maltreatment with the goal of preventing its reoccurrence.[32]

Five (5) of the six (6) regional CCPT/CRPs reporting, which represents 78 counties, recommended the need by expand prevention services in their regions. The need was stated as a lack of prevention services including effective parenting and support services for families involved with the child welfare system or at-risk for involvement. The regional CCPT/CRP cited lack of funding for prevention services as a factor in increased reports of child abuse and neglect in their regions. Although evidence-based parenting programs are exceptionally beneficial to the North Carolina child welfare system, there is currently no coordinated, statewide system or policy for administering said service.[33] Consequently, the responsibility rests with each local county DSS to oversee parenting program for the families that it serves. Fundamentally, this delivery method does not truly provide consistency or accountability to parents.

Outcomes:
An effective statewide child maltreatment prevention initiative should provide an array of universal, selective, and indicated child maltreatment prevention activities. Historically, North Carolina has focused the majority of its efforts and resources on indicated strategies, targeting individuals or families that have experienced abuse with the goal of preventing its re-

[32] IOM New Directions for North Carolina (2005)
[33] IOM New Directions for North Carolina (2005)

occurrence. Little state-level attention has been directed toward preventing child maltreatment from occurring in the first place.[34]

To effectively reduce child maltreatment in North Carolina, state and local communities must shift attention and resources towards pregnancy and the early years of childhood (birth to five years) because those developmental periods offer the best "windows of opportunity" for helping families develop nurturing, responsive relationships that promote healthy child development. This would require community and institutional support of parenting, including support and services for every expectant family and parents with young children. Services should then be added to this universal base of support through programs such as parent education and home visiting, which respond to the developmental needs of the child or the evolving parent-child relationship. Such a prevention system would help all parents and children before abusive/neglectful behaviors become established and difficult to modify; promote help-seeking behavior as a normal and expected activity for all parents; and provide more targeted services to higher-risk families. An effective child maltreatment prevention system should integrate services across public and private agencies, and be culturally and linguistically appropriate.

The system should be built around evidence-based and theory-based models that have been shown to work, in order to ensure that limited resources are used most effectively. Further, sufficient resources should be allocated to ensure the program staffing, training, technical assistance, and evaluations are adequate to successfully implement a child maltreatment prevention effort. Four (4) of the six (6) reporting CCPT regional teams cited lack of prevention services as a need in their local communities[35].

The desired outcome is a coordinated, consistent system for delivery of evidence-based prevention services available in all 100 counties. Further, the regional CCPT/CRPs recommended provision of said services in collaboration with a statewide organization that would provide family strengthening programs based upon an evidence-based parenting education curriculum utilized statewide with transportation for parents provided. Additionally, these parenting programs should be offered on a regular basis and after normal business hours to accommodate parents who work traditional day-time hours.

Educating parents about child behavior/development, shaken baby syndrome, chronic medical conditions and mental illnesses, and other topics are other strategies identified by the regional CCPT/CRPs to strengthen families and protect children from ever having to experience child maltreatment. Expanding parent education, support, and prevention services within the state would teach families how to communicate effectively, maintain healthy interactions, and cope with adversity. Ultimately, providing universal family strengthening programs statewide would place our children in a better position to be protected from child maltreatment. The following recommendations are broken into the following categories: general, curriculum funding, special populations, and public awareness.

[34] Ibid

[35] *New Directions* for North Carolina

Recommendations[36]

General:

- The state and county should identify and appoint a stable, reliable organization or agency that is capable of providing parenting classes on a regular basis.

- Services must also be available after normal business hours to accommodate employed clients.

- Intensive (in-home) and non-intensive family education.

- Provide incentives to encourage public/private partnerships at the local level to plan and implement parenting education programs that will meet the needs specific to that community.

Curriculum:

- Evidence-based program models for most effective outcomes [should be implemented].

- The state and counties [should collaborate in identifying] a parenting education curriculum that can be used across the state to ensure that all clients are afforded the same benefits of parenting classes. This curriculum should include:
    - Basic parenting skills, responsibilities of a parent and resources.
    - Specialized sessions such as: parents involved in drugs, domestic violence, parents of children with mental health issues, separated or single parents, gangs, etc.
    - Programs for all ages of children to help parents learn alternative parenting techniques.
    - Provide for educational programs on chronic medical conditions for those outside of the medical field working with families to ensure proper understanding of the needs of the family.

- Parents should have access to inexpensive or free training or educational seminars to them in various parenting techniques and areas of child development[37]. Early childhood education seminars to cover issues such as:
    - Shaken Baby (Period of Purple Crying)
    - Back to Sleep-this includes co-sleeping
    - Proper car seat placement
    - Safe child
    - Fire code law

Funding:

- Effectuate these outcomes [evidence based parent education programs provided by qualified personnel] through state funding appropriated for the sole purpose of providing parenting skills, transportation to and from the classes when needed and for support services provided by these organizations.

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[36] Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

[37] Listed as an outcome in the regional report but also serves as a recommendation

- Support; more funding [for the provision of evidence-based parent education programs].

- State provided funding for the strengthening of these educational programs to include home visits by trained professionals to ensure knowledge is being correctly learned.

Special Populations:

- Gang awareness and prevention through after school activities, positive recreational activities for children, school drop-out prevention, involvement in neighborhood watches, and cooperation with law enforcement.

- Prevention services for the education of teen parents, STD prevention, parenting for adults, education of Hispanic or other populations of minimum standards for care, supervision and discipline, and safe sleep guidelines. This education should be provided both in English and Spanish.

- To support families by providing resources, outreach, education, and support to enhance and preserve the family unit. Such supports may include but are not limited to mentoring, intensive (in-home) and non-intensive family education, after-school care and recreational opportunities.

Public Awareness:

- Make public awareness materials available to all counties on timely topics like the dangers of "the choking game", and the Surrender Law. These materials need to be designed in a way that they can be easily customized with local contact information.

Recommendation 7

Transportation

Need:
The lack of accessible transportation services for families was cited as a need or problem within three (3) of the reporting regional CCPT/CRP's end-of-year report. Rising gas prices are affecting all North Carolina citizens. However, prior to the increase in gas prices, transportation has frequently been cited as a major barrier to access of service. While three (3) regional CCPTs recognized the need for enhance transportation services, only one regional CCPT/CRP team made specific recommendations.

Outcome:
The desired outcome is accessible, affordable transportation services available to all citizens with out their own transportation to attend necessary appointments.

Recommendations[38]

[38] Recommendations are cited verbatim (except where noted] from the region CCPT reports. Full reports are provided in Appendix A.

- County and City officials within county develop a transit system that will meet the needs of transportation.

Recommendation 8

Day Care Services

Need:
A lack of access to affordable quality day care services for low to middle-income families was cited as a need by three (3) of the six (6) reporting regional CCPTs/CRPs. A number of familial and environmental stressors increase a family's risk for child maltreatment. To the extent that North Carolina can reduce these risk factors on a population basis, it can be expected that the incidence of child maltreatment will decrease. One specific risk factor includes unavailable or inadequate childcare which was cited as a need in 28 communities.

Outcome:
The desired out come is access to safe, affordable traditional and non-traditional daycare services that are available 24 hours a day/ 7 days a week.

Recommendations[39]

- Indentify available local, state, [and/or] federal funding sources[40]
- State/Identify available daycare.
- Increase funding [for day care services].
- Partner with local chamber of commerce and industrial development commission, employers, county agencies to develop a plan to address gaps.
- Training and review of any updates should be disseminated to all agencies and their staff. Each agency will be responsible for notifying CCPT of updates or changes to best practice policy.
- Increase the funding for quality, affordable daycare throughout the state and decrease or eliminate waiting lists.

[39] Recommendations are cited verbatim from the region CCPT reports. Full reports are available in Appendix A.
[40] Listed as an outcome in the regional report but also serves as a recommendation

Recommendation 9

Regional Juvenile Crisis Center

Need:
The lack of a safe environment for juveniles "with mental health issues or family emotional issues" was cited as a need by one regional team which represents 19 counties.

Outcome:
The desired outcome is a juvenile crisis center with well-trained staff to provide a safe environment for juveniles "with mental health issues or family emotional issues."

Recommendation:[41]

- Collaborate with mental health and religious organizations in identifying funding resources for establishing and operating a juvenile crisis center.

Recommendation 10

Services for Undocumented Residents

Need:
North Carolina has a rapidly growing Hispanic population, many of whom are "undocumented" and therefore unable to access many of the public social services. One regional CCPT cited the inability for families to access services if they are undocumented residents as a need.

Outcome:
The provision of services that enhance the quality of life to all persons residing in North Carolina regardless of legal status.

Recommendations[42]

- Fund programs that would assist undocumented aliens in enhancing their quality of living.

[41] Recommendations are cited verbatim from the region CCPT reports. (See Appendix A)
[42] Recommendations are cited verbatim from the region CCPT reports. (See Appendix A)

The final recommendation falls within a "best practice" category. This recommendation crosses multiple agencies.

Recommendation 11

Best Practice Principles

Need:
Inconsistent application of best practice principles across the state by agencies, public and private, that work with children and families including, but not limited to, the Department of Social Services, the Mental Health System, School System, Day Care, and Department of Defense was cited as a need by one regional CCPT/CRP.

Outcome:
The desired outcome is consistent application of best practice principles to ensure that quality service delivery will be offered to children and families. The following recommendations were primarily made by one regional CCPT/CRP; however additional regional CCPT/CRPs contributed to the recommendations through their reports.

Recommendations[43]

- Education of new and current child welfare staff on the Child and Family Services Reviews.

- [DSS] Social workers to have better access to National Criminal Record checks all social workers should become DCI trained in order to complete National Criminal Record checks.

- Develop and follow the MOU/MOAs established with the Department of Social Services, Law Enforcement, Department of Defense, Mental Health, local school system for consistent collaboration.

- Training and review of any updates should be disseminated to all agencies and their staff. Each agency will be responsible for notifying CCPT of updates or changes to best practice policy.

- Counties must have a method of notifying all agencies with contact numbers for after-hours personnel and phone numbers when applicable. This information must be kept current.

[43] Recommendations are cited verbatim from the region CCPT reports. (See Appendix A)

- Decrease [in DSS] turnover rate, low wages, and extensive caseloads among county Social Workers.

- Increase [DSS] staff education and consistent application of best practice.

NC State Fatality Review Team Recommendations

State Child Fatality Review Team Recommendations:
The NC State Child Fatality Prevention Team (State Team) was designated as the entity to complete the 2007 CCPT/CRP Annual report. While the NC State Child Fatality Prevention Team was not asked to provide specific recommendations to this report, the State Team believes it would be remiss in its duties without make systemic recommendations to enhance this new regional team approach. The regional structure is a new for everyone involved: NC-DSS, the regional CCPT/CRPs, and the State Child Fatality Team. The NC State Child Fatality Prevention Team believes we can all learn important lessons from this process to better meet the CAPTA mandates, but more importantly to strengthen child welfare services in North Carolina.

In developing the following recommendations, the State Team considered many factors. First, we concerned about the effectives of the Regional CCPT/CRPs without the establishment of an orderly documentation, communication and facilitation process for the advancing of the CRP agenda which is systematic program improvement with measurable outcomes. This process can create a great deal of value for system improvement based on objective, quantitative information, thus rendering CCPT/CRPs contributions valuable to all of NC citizens.

There is a considerable amount of confusion; both on the state and community level, about the roles, functions and accountability of the local CCPTs, Regional CCPTs, and CRPs. Therefore clarification will be needed if this system is to be effective. Additionally, the new regional structure must be supported in developing their own capacity to be effective monitors of the child welfare system. Many states have elected to contract with an outside agency for this service for optimal outcomes.

CAPTA legislation did not specify the composition of the three mandated CRPs. The North Carolina local and regional system for CCPTs/ CRPs is complicated and confusing—even to professionals. Several states have been very creative in development of their CRPs to meet best practice outcomes. For example, at least one state is modeling the CRPs after the federal child and family services reviews. Panels are located in three selected counties (rather than a statewide representation).

Membership in the North Carolina CCPT/CRPs does not meet the federal requirements. First, teams must be composed of volunteer members who are broadly representative of the community, as well as members with expertise in the prevention and treatment of child maltreatment[44]. Teams should also include parent/consumer representatives. While the Regional CCPTs strive to be sensitive to cultural, ethnic and economic diversity and to broadly represent the community at-large, diversity in membership varied by region. Members of regional teams are volunteers. Therefore, it is not surprising that the regional teams were heavily

[44] CAPTA, 1996

comprised of "experts" – primarily employees of local agencies and organizations with few "concerned citizens" and /or parent/consumer representatives. However, all regional CCPTs did have at least one citizen or parent/consumer representative.

All of the regional teams had strong DSS representation in their membership. On average, about 40% of the regional CCPT/CRP members were employees of local DSSs. DSS membership on teams varied from region to region, ranging from 10% to 69% of membership comprised of local county departments of social service employees. The teams were also comprised of a variety of community agencies and organizations including: local health departments, public school staff, guardian ad litems, local Partnerships for Children, the faith community, and various community-based agencies. However their was little or no representation from target populations such as: Native Americans, Hispanics, and/or the military.

Finally, the regional CCPT/CRP were not provide the state's CAPTA plan and therefore could not evaluate the extent to which the state is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan which is one of the mandates for CRPs. Additionally, based on technical assistance provided to a subcommittee of the NC Child Fatality Prevention Team by the University of Kentucky, there is the possibility that the new regional CCPT/CRP does not meet the federal intent and guidelines for Citizen Review Panels. Therefore the following recommendations are made:

The following are systemic recommendations made by the NC Child Fatality Prevention Team:

State-level Recommendation: Improve Organization, Structure and Process:

- To defuse the confusion regarding the roles and functions of the Community Child Protection Teams (CCPT), Citizen Review Panels (CRP), and Regional Community Child Protection Teams (RCPT): Develop a document or presentation that describes the roles and outputs (products) of each of the three distinct teams produce, and clarifies the different functions they serve.

- Consider renaming the Regional Community Child Protection Teams so they have a clear, distinct name [such as the Regional Citizen Review Panels' (CRP)].

- Consider reorganizing the Regional CCPT structure so that representative counties (like those selected for the Child and Family Services Review) participate rather than requiring all 100 counties to participate.

- Locate and secure an "organizational home" to provide training and support to the Regional CCPTs, receive recommendations from the Regional CCPTs, write the annual report, and make recommendations based on the regional reports. This could be a university, statewide non-profit agency (such as PCA-NC), or public-private entity (such as the Child Maltreatment Prevention Leadership Team). Dedicated funding will need to be provided to the "organizational home" to support the activities of the Regional CCPTs.

- Develop an annual reporting timeline for Regional CCPTs and "organizational home" members. (see Training and Technical Assistance section for details)

- Develop and implement training for Regional CCPTs and "organizational home" members on making quality recommendations and preparing reports in a timely manner. (see Training and Technical Assistance section for details)

- Develop a detailed reporting template for Regional CCPTs that they submit electronically to the "organizational home."

- Support local and regional CCPT efforts to include private citizens (including special populations).

- Include a review of local and regional CCPT membership and participation records as a part of the CFSR-biennial review process.

State-level Recommendation Provide Training and Technical Assistance for CCPTs/CRPs

- Make sure the Regional CCPTs and "organizational home" members are trained on the following:
    - CAPTA requirements and reporting expectations
    - Use of the electronic template for making recommendations in a manner that address CAPTA requirements (the template should provide clear, detailed instructions on writing and submitting recommendations).
    - a timeline that allows adequate time to collect the data from local CCPTs, write a Regional report, submit Regional reports to the "organizational home" and still allows the "organizational home" time to draft and submit a quality report

- Provide (or contract with the "organizational home" to provide) technical assistance to local CCPTs and regional CCPTs throughout the reporting process.

Local/Regional-level Recommendation: Develop Team Membership

- Local and Regional CCPTs should develop and implement a plan to ensure that team membership includes private citizens as well as professionals. Members should represent the diversity of the community, including racial/ethnic/cultural diversity as well as unique populations within the county or region (such as military representatives and/or other special populations).

- Local CCPTs could increase private citizen participation in meetings and the writing of recommendations and reports by:
    - approaching County Commissioners and asking them to appoint private citizen

- Regional CCPTs could increase private citizen participation in meetings and the writing of recommendations and reports by:
    - holding meetings after hours using technology (conference calls or webcasts) to reduce travel costs and as well as participation.

Required Response to the Annual Report:
The North Carolina Division of Social Services (NC-DSS) is accountable for replying to the recommendations in this report as the administrator of the CAPTA grant which assures the implementation of the State's Child and Family Services Plan. Because the protection of North Carolina's children is not the sole responsibility of one agency, there are recommendations which are outside the control of NC-DSS. For recommendations that NC-DSS can not implement alone or require other agencies to address or adopt, NC-DSS will seek answers and remedies to these recommendations, similar to the process they are undertaking through the Program Improvement Process (PIP). A written response is due within 6 months; however the Division plans to respond by September 15, 2008.

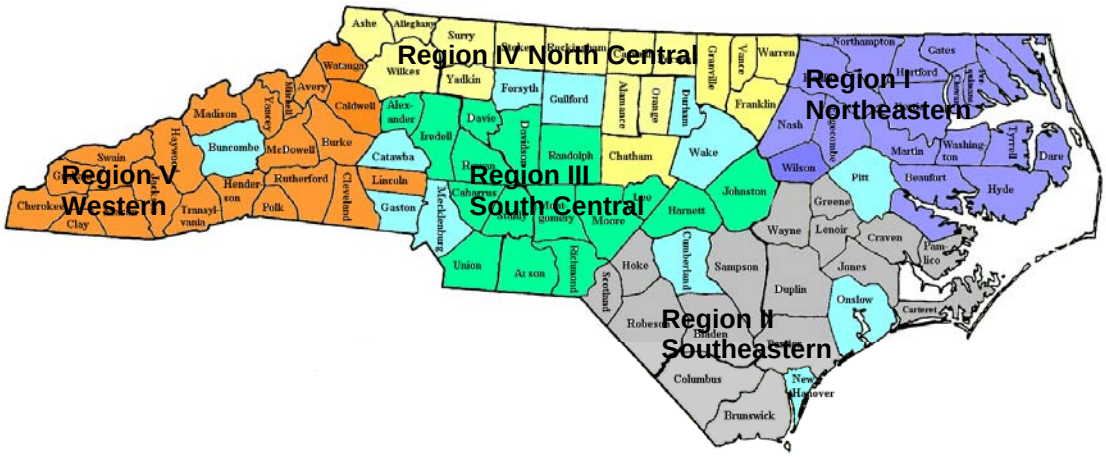
Appendix A

Regional CCPT Reports

Region 1: Northeastern

Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Nash, Northampton, Pasquotank, Perquimans, Tyrell, Washington, and Wilson

Regional Community Child Protection Team



Region 1 Community Child Protection Annual Report

MEMBERS PARTICIPATING IN DEVELOPING THE REPORT

Andrew Payne-Wilson County
Carol Cobb-Edgecombe County
Christy Nash-Wilson County
Debbie Cook-Nash County
Eva Rogers-Nash County
Gloria Braddy- Bertie County
James Yates-Chowan County
Jeff Mitchell-Dare County
Kay Overton-Washington County
Linda Roberts-Beaufort County
Mary Jo VanHorne-Franklin County
Melissa Ferrell-Currituck County
Michele Braswell-Halifax County
Pandora College-Tyrell County
Sara Lane-Camden County
Susan Davenport-Martin County
Terry Bell-Northampton County

BRIEF OVERVIEW OF CHILD WELFARE WITHIN THE REGION/STATE

In the CCPT Regional District 1, there are a myriad of needs and gaps in services that affect child welfare. One of the foremost issues is the problem with the current mental health system as it affects a broad range of issues, such as lack of specialized treatment for domestic violence offenders, lack of specialized treatment for sexual abuse offenders, lack of substance abuse treatment centers, lack of therapeutic placements for children and other specialized treatments. Transportation, appropriate, affordable housing, unemployment and a general lack of services and support, including parenting classes are reoccurring barriers to permanency for children. There is a need for after school activities and positive, affordable recreational activities for youth with a focus on drop out prevention, gang prevention, teen pregnancy and unsafe sexual practices, and independent living skills.

SPECIFIC TEAM ACCOMPLISHMENTS DURING 2007

In each county, cases were reviewed, which led to education of CCPT members on the abilities and purposes of various agencies and organizations. Presentations and community awareness campaigns on issues such as reporting child abuse and neglect, gang awareness, safe surrender and basic safety practices for children were conducted by most counties. Some of the specific accomplishments of individual counties were as follows:

Beaufort County

- Publicly recognized local restaurants that had remained or become smoke-free environments
- Placed a variety of PSA's on the local cable access channel regarding child safety.
- Addressed areas of water safety during the summer, reminders about seat belts and child seats and general guidelines to concerning positive interaction with children.

Camden County

- Discussed more issues such as safe surrender and gang activity that raised more awareness among team members.

Chowan County

- Promoted awareness of gang activity and how it negatively impacts and communities and families. The county now has a gang task force that meets regularly to address continues concerns about gang activity.

Currituck County
- Made stakeholders and local politicians aware of serious system flaws and deficiencies

Dare County
- Shared information and collaborated

Edgecombe County
- Worked with DSS to provide a system of case review identification
- Combined with the CFPT to address increasing mandated members and established a community awareness committee.
- The community awareness committee planned and conducted a domestic violence workshop with professionals. The committee collaborated with the local domestic violence task force and Nash County CCPT to accomplish this task.

Franklin County
- Held quarterly meetings, reviewed 8 cases, provided training to hospital staff on CPS issues, Full time juvenile law enforcement officer housed at DSS to investigate abuse cases.

Halifax County
- Brought the drop out problem in Halifax County to the attention of all three school systems and learned what each school system was doing or not doing to address the problem. We demonstrated a need for schools to follow Compulsory Attendance Laws and hold parents and school systems responsible for school attendance.

Hertford County
- Identified gaps/deficiencies in services and made appropriate recommendations for services.

Nash County
- A joint DV conference was held by professionals with our neighboring county CCPT. Recruitment of a new member who is the director of the local Domestic Violence program.
- Identified the need for additional school social worker to assist in reducing child maltreatment through early detection in family issues.

Northampton County
- Good interagency team communication. Shared knowledge of resources.
- Educated the community of increased gang awareness in the county. Involved in the building of a new recreational facility in the county.
- Improved on what we are required to do for our families.

Pasquotank County
- Case reviews that resulted in the team becoming educated and given information concerning the Homeless Coalition, Gang Awareness Task Force and mental health reform.
- As a result of one case incident, the team voted to provide written support to the legislators concerning the enactment of a child endangerment law that would hold parents accountable (felony vs. misdemeanor) for their actions or inactions that result in maltreatment to their children.

Perquimans County

- Increased awareness of when it is appropriate to report to child maltreatment to DSS.
- The team has also been working on getting fencing put up around a pond that is located in a parking lot of a grocery store in town.

Tyrell County

- A better understanding of the role of each team member. Their views and sharing of knowledge is a great asset.

Warren County

- Identified barriers to Child Protective Services

Washington County

- Continuing to advocate for mental health change, more resources and access to these services with county officials.
- Team Members received training concerning the CCPTs purpose, duties and responsibilities

Wilson County

- Added new members from the Faith Community, local Health Department, Mental Health Association, LME and Nurturing Parenting project.
- Created 6 new sub committees: Nurturing Parenting Program, Wilson Gang Task Force, Safe Surrender Task Force, Drug Endangered Children's Task Force, Work First Kinship Care Project, Ladies of the Future Together (LOFT) and the Community Resource Directory.
- Wrote two grants, one from the Governor's Crime Commission to address the issue of gang involvement of the elementary and middle school children, the other from Caring for Kids by Improving Diversity of Services (CKIDS) program to address the funding and case management needs of relative caregivers when they accept children into their home.
- Gave educational presentations on various services and programs at each monthly CCPT meeting.
- Wilson Gang Task Force held several community awareness workshops within the schools to promote Gang awareness and prevention efforts.
- Sponsored events such as a soccer camp, Christmas with the children and a Salvation Army Boys and Girls positive behavior and gang prevention presentation.

RECOMMENDATIONS

The following list of recommendations encompasses the stated needs and problems encountered in the counties comprising the Region 1 CCPT. All recommendations of the team are viewed as vital for the safety and success of the children within the region.

1. **Mental Health Reform**

   Objective/Outcome: All counties have a structure in place to offer timely, qualified, competent, continuous, specialized and effective mental health services, inclusive of transportation for clients.

   Recommendation: To meet the consumer's needs, mental health services should return to the one stop for assessment, treatment, inpatient and out patient therapy and medication management. Current mental health providers are in need of more supervision and oversight

from the state to ensure effective services are being provided to clients. The state should ensure that each county (or within a reasonable distance of the county) provides specialized treatment services such as those for domestic violence offenders, domestic violence victims, substance abuse offenders, sexual abuse offenders, victims of sexual abuse, psychiatric specialties, etc. These services should be identified, and placed on an updated website for easy accessibility.

2. Foster Home Training and Licensing

Objective/Outcome: Sufficient number of foster homes trained and licensed in order to keep children inside their communities when coming into foster care.

Recommendations: The Children's Home Society will certify and DSS can license if no MAPP trainer is in the county. Local DSS to be informed of train the trainer classes.

3. **Regional Juvenile Crisis Center**

Objective/Outcome: Establish a juvenile crisis center with well-trained staff to provide a safe environment for juveniles with mental health issues or family emotional issues.

Recommendations: Collaborate with mental health and religious organizations in identifying funding resources for establishing and operating a juvenile crisis center.

4. Judicial Process is Delaying Permanence for Children

Objective/Outcome: TPR filing and completions are timely within ASFA guidelines

Recommendations: Training for judges and attorneys on awareness and impact of judicial delays in relation to child permanency. Need exists for a protocol to put in place in which Chief Judges are notified of delays and a plan to be developed to address delays. For social workers to have better access to National Criminal Record checks. Social workers to become DCI trained in order to complete National Criminal Record checks.

5. Parenting Education

Objective/Outcome: Clients in need of parenting skills receive parenting classes that are instructed by qualified personnel based upon accredited programs. These classes must be offered on a continuous basis to meet the specific needs of the clients as they are identified, inclusive of transportation.

Recommendation: The state and counties identify a parenting education curriculum that can be used across the state to ensure that all clients are afforded the same benefits of parenting classes. This curriculum should include basic parenting skills, responsibilities of a parent and resources. The curriculum should also include specialized sessions such as: parents involved in drugs, domestic violence, parents of children with mental health issues, and separated or single parents, gangs, etc. The state and county should identify and appoint a stable, reliable organization or agency that is capable of providing parenting classes on a regular basis to provide these classes. Effectuate these outcomes through state funding appropriated for the

sole purpose of providing parenting skills, transportation to and from the classes when needed and for support services provided by these organizations. Services must also be available after normal business hours to accommodate employed clients.

6. Gang Awareness/Prevention

Objective/Outcome: Counties gain more awareness of gang activities and gang prevention through after school activities, positive recreational activities for children, school drop out prevention, involvement in neighborhood watches and cooperation with law enforcement.

Recommendation: Counties create a Gang Awareness/Prevention Task Force, if one is not already in the county. Task Force team up with existing programs/agencies to deal with drop out prevention, juvenile delinquency, recreational opportunities, mentoring programs, and other programs that could help in the awareness and prevention of gang activity.

7. Lack of Transportation

Objective/Outcome: Citizens without access to their own transportation have access to transportation enabling citizens to attend necessary appointments.

Recommendation: County and City officials within county develop a transit system that will meet the needs of all citizens in need of transportation.

Respectfully submitted,

Terry L. Bell, Region 1 Team Leader

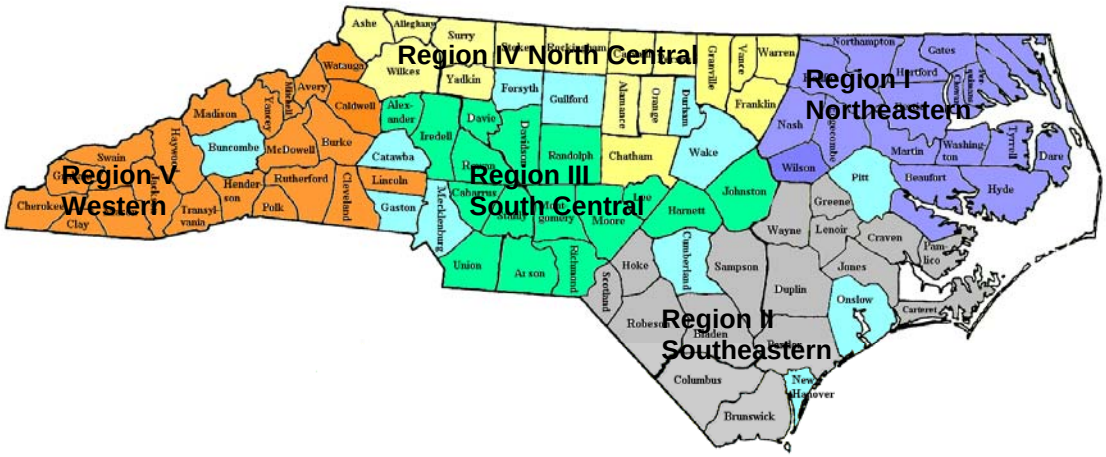
End of Region One Report

Region 2: Southeastern

Bladen, Brunswick, Columbus, Carteret, Craven, Duplin, Greene, Hoke, Jones, Lenoir, Pamlico, Pender, Robeson, Sampson, Scotland and Wayne

No Report Received

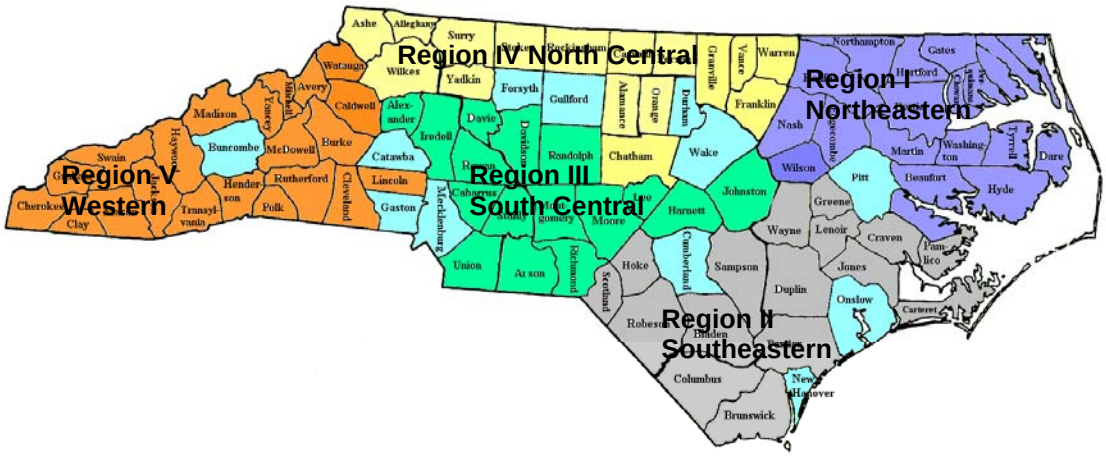
Regional Community Child Protection Team



Region 3: South Central

Alexander, Anson, Cabarrus, Davidson, Davie, Harnett, Iredell, Johnston, Lee, Montgomery, Moore, Randolph, Richmond, Rowan, Stanly and Union

Regional Community Child Protection Team



CCPT REGIONAL END OF YEAR FORMAT

REGION III

MEMBERS PARTICIPATING IN DEVELOPING THE REPORT:

Sara Messer, (Lee), Anne Laukatitis (Cabarrus), Cindy Hendricks (Davie), Wilma Laney (Moore), Kathy Hitchcock (Davidson), Mary O'Neal Mauney (Union), Sharon Scott (Stanly), Elizabeth Blair (Rowan), Kathy Hitchcock (Davidson), Alice Lammonds (Montgomery County).

BRIEF OVERVIEW OF CHILD WELFARE WITHIN THE REGION/STATE

Overall Region III is satisfied that DSS in the various counties are doing a good job in their assessments of family needs and providing services to the families. The regional group, however, does feel that there are gaps within the community with information on how to report suspicions of neglect or abuse, when to contact DSS with suspicions of abuse/neglect and what the agency's roles are within the county. There is also a lack of understanding about mandatory reporting laws, where law enforcement, school systems, etc. are not making reports due to their lack of knowledge or concern about "whether or not something will be done." Region III all seemed to have a positive attitude with the school systems within the region and feel that the children's needs are being met with programs set within the counties to assist those children with needs.

SPECIFIC TEAM ACCOMPLISHMENTS DURING 2007:

- Union County raised awareness of child-on-child sex abuse through community dialogue, identified funding source for treatment of youthful offenders;
- Rowan County supported a ban of sex offenders in public parks and a guardian was obtained for an adult teen aging out of care and established a plan for involuntary commitments;
- Stanly County team became more aware of the challenges that many of the community agencies face in the provision of services to children and families;
- Davidson County team participated in continued awareness for Safe Surrender campaign, made recommendations to driver's education program;
- Alexander County addressed gaps in MRS and services, addressed service needs of domestic violence, substance abuse and child maltreatment;
- Lee County had public awareness campaign for water safety (English and Spanish) for families for better supervision around ponds, lakes, pools and in bathtubs, campaigned for fire safety within the school system (k-12)to address those families who did not know how to get themselves and others to safety during a fire, worked with drivers education program to ensure beginning drivers are being taught offensive driving (such as overcorrecting, etc.) because of a high number of car fatalities amongst teens;

- Cabarrus has continued a campaign that began six years ago to protect infants and toddlers through educational materials and videos distributed at the hospital. These materials were distributed to parents of all newborns, DSS and the Cabarrus Health Alliance. The Cabarrus Partnership for Children maintains a special fund to assist social workers with critical needs for infants and toddlers, such as car seats, cribs, etc.

RECOMMENDATIONS:

1. **NEED/PROBLEM:**
   Inconsistent, unobtainable and unavailable mental health resources for children and adults.

   OBJECTIVE/OUTCOME:
   Strategically focused mental health services to target children and adults with substance abuse issues, teen sexual offender treatment, treatment of abused and neglected children, and treatment for victims of domestic violence.

   RECOMMENDATIONS:
   State to further reform the mental health system so that children and families within the community can receive affordable and effective treatment for substance abuse, sexual offender treatment for our teens, domestic violence victims, and treatment for children who have been abused or neglected.

2. **NEED/PROBLEM:**
   Fatality reviews and practice across the region have shown a lack of awareness and knowledge of when to report incidents of child abuse and neglect. There is a lack of understanding of MANDATORY reporting laws and services provided by DSS and within the community.

   OBJECTIVE/OUTCOME:
   Statewide community awareness of mandatory reporting laws and services provided by DSS and within the community, and how to report child abuse and neglect.

   RECOMMENDATION:
   The state provide funding for community awareness posters and public service announcements as well as a DVD geared specifically towards law enforcement, medical professionals and citizens within the community.

3. **NEED/PROBLEM:**
   Lack of funding for prevention services has led to an increase in abuse and neglect referrals.

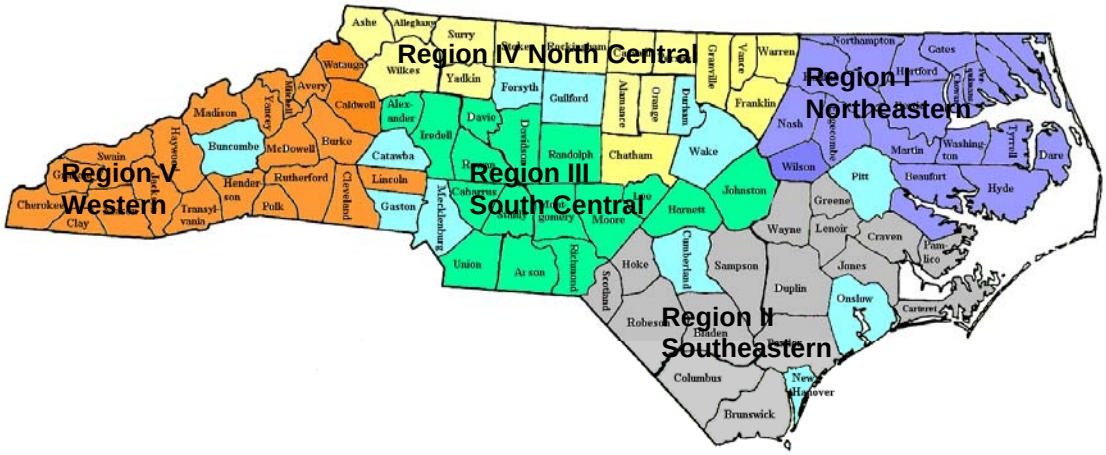
   OBJECTIVE/OUTCOME:
   To strengthen preventive services for the education of teen parents, STD prevention, parenting for adults, education of Hispanic or other populations of minimum standards for care, supervision and discipline, and safe sleep guidelines. This education should be provided in both English and Spanish.

   RECOMMENDATION:
   State provided funding for the strengthening of these educational programs to include home visits by trained professionals to ensure knowledge is being correctly learned.

Region 4: North Central

Alamance, Alleghany, Ashe, Caswell, Chatham, Franklin, Granville, Orange, Person, Rockingham, Stokes, Surry, Vance, Warren, Wilkes and Yadkin

Regional Community Child Protection Team



Need/Concern	Objective/Outcome	Recommendations
Children remaining in foster care for months or years beyond the one-year mandate for permanency.	Permanency will be achieved for children within one year.	1. Remove financial barriers to children achieving permanency through custody and guardianship agreements by reallocating foster care dollars currently being paid to maintain placements for children until they age-out of foster care. 2. Use that money to pay for subsidized custody and guardianship agreements to provide financial support for children for whom reunification is no longer the goal but termination of parental rights is not in the best interests of the children, and custody and guardianship offers the best and only chance for achieving permanency instead of having children age-out of the foster care system.
Family stability is adversely affected by many factors including unemployment, underemployment, domestic violence, lack of transportation. Lack of medical insurance, substance abuse and absent parent or parents. Family instability contributes directly to quality of child physical and mental health: in nutrition: in modeling of violence, smoking, substance abuse: to school attendance and performance: all impacts on a child's success or failure as a citizen of his or her community. Family instability diverts parental energy, supervision, and responsibility from child issues such as: screen time (content and time spent on TV, computer); physical activity and recreational opportunities; gun safety, risky behaviors, gang affiliations, depression and suicide.	To support families by providing resources, outreach, education, and support to enhance and preserve the family unit.	1. Mentoring 2. Intensive (in-home) and non-intensive family education 3. After-school care and recreational opportunities 4. Support: issues cannot be addressed effectively without funding. 5. Evidence-based program models for most effective outcome.

Children and their families are not receiving the care and attention top their mental health needs due to the mental health reform which increases their vulnerability and escalation of issues with domestic violence, child abuse and neglect, substance abuse and depression. Often their mental health needs go untreated or they do not have the money for medication and treatment	Mental Health services to more consistent, affordable, and comprehensive for all children and families.	1. Stabilize Mental Health System a) Increase qualified mental health providers b) Increase the number of licensed psychiatrists c) Increase Substance Abuse Programs to address: • Prescription Drug Abuse • Teen Substance Abuse (including prescription and OTC) d) Domestic Violence • Evidenced based programs • Programs that address entire family needs • Perpetrator treatment • Children witnessing domestic violence and Post Traumatic Stress Syndrome e) LME's need more authority on case decisions. They have first hand knowledge from local providers and community agencies working together through System of Care f) Mental Health Case uninsured

Region IV Counties: Alamance, Alexander, Alleghany, Ashe, Caswell, Chatham, Person, Orange, Rockingham, Stokes, Surry, Wilkes, Yadkin

Membership: Robin Testerman, Linda Devine, Betty McGurk, Amanda Reeves, John Coiro, Nanci Shannon, Diane Rocker, Carmen Coley, Tim Murphy, Callie McBroom, Ken Richardson, Tonia Goad, Erin Eskridge, Tammy Chaney, Cathy Waugh, Lee Cornett, Hillary Carroll

Overview of Child Welfare in Region IV: Counties in Region IV have strong local community child protection teams that face the same overall issues and concern for children and families

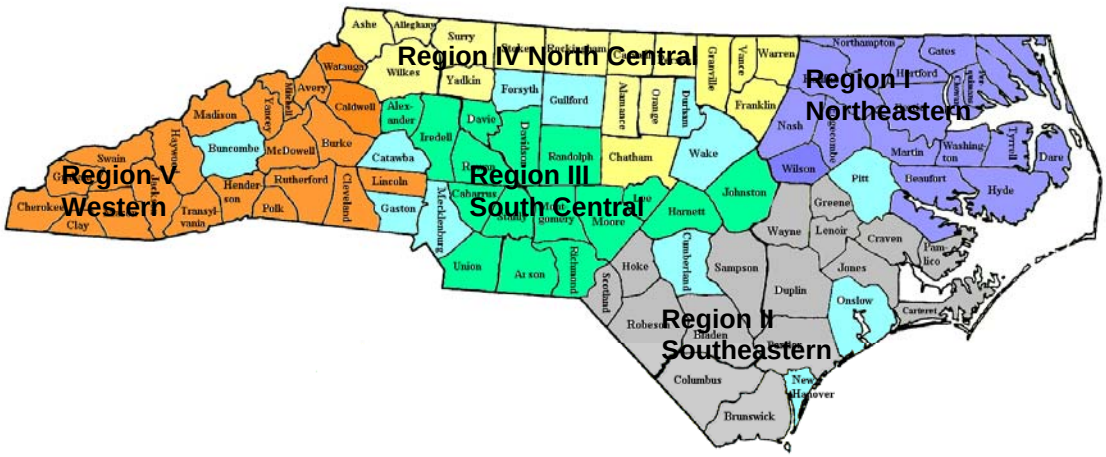
- Domestic Violence
- Substance Abuse
- Metal Health Issues – lack of consistent treatment
- Chronic Neglect
- Lack of transportation services for families
- Sexual Abuse
- After School Resources and Activities for middle and high school children
- Lack of funding for prevention and intervention programs for child abuse and neglect

Region 5: Western

Avery*, Burke, Caldwell, Cherokee*, Clay, Cleveland*, Graham*, Haywood*, Henderson, Jackson, Lincoln, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga*, and Yancey

* Did not submit an end-of-year report to the regional team

Regional Community Child Protection Team



Region 5
CCPT Regional End-Of-Year Report
For 2007

Members participating in developing the report

Alisa W. Ashe	Macon County
Cathy Brooks	Polk County and Rutherford County
Vanessa Henley	Avery County
Kelly Icenhour	Avery County
John Lewis	Madison County
Lou Parton	Polk County
Kathie Williams	Transylvania County

The following information is a summary of the reports submitted by 15 of the 21 counties in the region.

Overview of Child Welfare within Region 5

Region Five (5) is comprised of 21 counties in Western North Carolina, most of which are rural counties each comprised of a few cities, towns or municipalities along with small communities and clusters of multi-generational families living in remote areas. In these small communities, citizens often hesitate to report child abuse or neglect because the families involved are relatives, neighbors or friends. Across the region, there is a pressing need for more public awareness of the legal obligation of all North Carolina citizens to report suspected abuse or neglect.

In 2007, local Community Child Protection Teams reviewed a total of 584 cases across the region. As reflected in the county year end reports, in the cases reviewed by local CCPTs there were several issues and barriers identified that were common across the region.

Substance abuse by parents continues to be identified as being a major factor or condition that most often was the cause of children being unsafe in their own homes. The team found: 1. These parents began their substance use in their early teen years. 2. Many of these parents lived in families with intergenerational substance abuse issues. 3. There is strong correlation between criminal activity and substance abuse specifically with domestic violence. 4. On-going substance abuse contributes to unstable living environments. 5. Prenatal substance use contributes to difficult behaviors in children resulting in behavior management issues for parents, child care staff and school personnel.

The complexity of mental health issues has increased, thus the need for more intense and timely mental health services to children and families receiving Child Protective Services. Untreated parental mental health issues (i.e. depression, suicide attempts, Post Traumatic Stress Disorder) contributes to child abuse and neglect. Difficult behavioral issues of children in day care and school are greatly impacted by the lack of parental mental health treatment.

The lack of accessibility, affordability and availability of appropriate Mental Health services and Substance Abuse treatment strongly stands out as a major barrier to permanency for children involved in child welfare cases and also is consistently listed as one of the top barriers to child protection.

The lack of resources as a barrier to child protection and also a barrier to permanency for children, commonly appeared in the local reports. Some of those resources frequently listed are: Lack of enough adoptive parents and family foster care homes and therapeutic foster care, lack of adequate day care funding, lack of transportation and lack of jobs.

Court delays, continuances and scheduling problems are also commonly listed as barriers to permanency.

The turnover rate, low pay and increasing workload for Social Workers is a continuing concern of the local teams.

(See full lists of barriers in the attachments to this report.)

Specific Team Accomplishments During 2007

We acknowledge that sharing information and public awareness campaign ideas may become a significant component of the Regional CCPT meetings. In preparing this report the participating members learned the following things about their surrounding counties:

1. Several counties cited increased public awareness campaigns as the team's accomplishments for 2007.

2. Two counties sponsored events that were direct results of recent situations that took place in the counties. In response to a child's death, a public forum focusing on risky behaviors in adolescents and teens was held. This included discussion and literature for parents which listed some of the signs to watch for which might indicate their child is experimenting with "the choking game" and other currently popular risky behaviors. The second county's event was in response to an infant's multiple injuries caused by abuse that went unidentified in visits to the ER. The CCPT co sponsored a workshop on abuse identification for ER staff, school counselors and school nurses and other local professionals.

3. Three counties had received positive actions from County Commissioners in response to needs Identified or supported by the local CCPT. This included salary adjustments for CPS workers in one County, a new Community Service Assistant position in one county and positive responses for a poster campaign around young mothers bonding with their babies.

4. One county participated in a major community undertaking to create a United Agenda for Children.

(See complete list of individual county accomplishments in the attachments to this report)

Recommendations

1. Need or problem:

There is a lack of availability, access and affordability of appropriate Mental Health services and Substance Abuse treatment. The existing Mental Health system is difficult to navigate not only for families in need of services but also for the professionals involved. Untreated parental mental health issues and substance abuse contribute to child abuse and neglect, as verified in the majority of cases reviewed by local Community Child Protection Teams.

Objective/Outcome:

Every North Carolina citizen has access to appropriate, affordable Mental Health Services and Substance Abuse treatment.

Recommendation to the State

- Allocate adequate funding to meet the Mental Health and Substance Abuse issues.
- Revise the "service definitions" so clients can get more adequate multiple services from the provider when needed.
- Broaden the service definitions to include a provider's training and experience so providers are receiving adequate payment to help reduce the turnover in providers.
- Expand recruitment of trained, experienced providers and fund incentives to retain good providers.

2. Need or problem:

There's a need for expanded Parenting Education opportunities and increased Parenting support Services. In the majority of rural communities, there is a great need to offer opportunities for parents to learn appropriate parenting techniques at all ages and stages of parenting. Topics like increasing awareness of the Safe Surrender Law, the importance of infant/parent bonding, the realities of Shaken Baby syndrome, parent/child interaction at all ages, identifying normal child development, identifying risky behaviors in adolescents and teens such as experimenting with drugs, sex, the "choking game", and inappropriate use of technology (internet, text messaging, etc.)

Objective/Outcome:

Better informed parents who have access and availability for parenting information and support to increase their ability to adequately raise their children in a safe, appropriate, nurturing atmosphere.

Recommendation to the State:

Provide incentives to encourage public/private partnerships at the local level to plan and implement parenting education programs that will meet the needs specific to that community. Make public awareness materials available to all counties on timely topics like the dangers of "the choking game", and the Surrender Law. These materials need to be designed in a way that they can be easily customized with local contact information.

3. Need or problem:

In Child welfare cases the emphasis on the child's need for permanency in a timely manner should be encouraged in the judicial system. Judges and Attorneys involved may need cross-training to enable them to take a more comprehensive view of the family situation, including the long-term mental health affects on children when they end up staying in out-of-home placements too long or end up returning to the inappropriate parenting situation too quickly.

Objective/outcome:
Make juvenile court a priority and have better coordination of non-conflicting court dates across county lines within a judicial district (same attorneys are serving adjoining counties and are often scheduled to be in court in more than one county at the same time).

Recommendation to the state: Develop a collaboration with law schools to do cross training for Judges and Attorneys on the different disciplines they'll be working with in Child Welfare cases and the developmental and mental health needs of the child.

4. Need or problem:

There are not enough adequate out-of-home placements available locally in most of our region's counties for children who have been abused and neglected. Almost every county in our region has to place children in out-of- county placements due to a lack of enough local foster care homes.

Objective/Outcome:
More placement options are available locally that meet the individual needs of the individual child, including regular foster care homes as well as therapeutic foster care settings.

Recommendation to the State:
Fully fund positions in local DSS agencies to do foster care recruitment and licensing and additional follow up training. Reduce the recommended case load on the foster care licensing worker. Develop more higher level therapeutic placement opportunities in the state. Dedicate more State DSS staff to process foster care home licensing applications.

In conclusion, on behalf of the 21 counties in the western part of the state, the Region 5 Community Child Protection Team wishes to thank the state of North Carolina for the opportunity to give input and recommendations in an effort to improve the well being and protection of all children in our communities.

Attachments to this report::

- Attachment I Total Cases reviewed in each county and frequency of meetings
- Attachment II Counties' barriers to permanency for children and barriers to child protection
- Attachment III Local Team Accomplishments listed by county and public awareness efforts

Attachment I

Total cases reviewed in each county and frequency of meetings

		CASES REVIEWED						
	Meets	CPS intake	CPS assessment	CPS in-home	Foster Care	Adoption	other	TOTAL
Burke	monthly	9			5	1	1	16
Caldwell	?		3	2	1			6
Clay	?		2		2			4
Henderson	monthly		2					2
Jackson	bi-monthly		30	15	10			55
Lincoln	monthly		31				3	31
Macon	monthly	120	25	95	30		44	164
Madison	bi-monthly	3		7	5			15
McDowell	quarterly		4	3	2			9
Mitchell	quarterly		4	2				6
Polk	bi-monthly	4	4	1	3			4
Rutherford	bi-monthly		2		1			3
Swain	?	50	50	84	25	3	36	248
Transylvania	?		4	1	2		2	9
Yancy	quarterly		3	7	5			12
						Total		**584**

NOTE: End of Year Reports were only available for 15 of the 21 counties in Region Five.
No reports were available for:

Avery
Cherokee
Cleveland
Graham
Haywood
Watauga

Attachment II ***(NOTE: number of X's indicate # of counties with same response)***

County's barriers to permanency for children

- **Lack of MH/SA services**
  - Easy access to mental health services for parents and caregivers
  - Available MH services, especially substance abuse services
  - Lack of MH services X X
  - Lack of appropriate MH treatment
  - Lack of substance abuse treatment programs locally
  - Lack of substance abuse services especially for youth
  - Better substance abuse services available for adults and teens

- **Parental compliance with case plans**
  - Parents failure to comply with case plans
  - Parents willingness to work on issues
  - Parent being in prison and having to work with that parent

- **Lack of Resources**
  - Lack of family support resources
  - Lack of funds for transportation and daycare
  - Not enough good adoptive parents X X
  - Lack of adoptive homes
  - Lack of foster care providers X X
  - Limited number of family foster homes, lack of funding for those homes
  - Placement resources for older children
  - Lack of school nurses

- **Court delays and appeals**
  - One judge per case, currently have a constant rotation of four judges
  - Not enough court days
  - Some court continuances at times
  - Attorneys not coming to court on the appointed court date
  - Lack of court Appointed Attorneys
  - Lack of available judges X X

- Less splitting in services, child and family teams only work when providers participate and work together for the families
- More education with law enforcement and the court systems with children's issues
- Interstate delays
- Ability to increase parent/child visitations because of workload
- Fed and State insistence to move children into permanency too quickly
- Judicial system is not on board regarding one year

- Drug use,
- Domestic Violence
- Transportation
- Need for change in State law
- Appropriate housing and livable wage jobs

County Barriers to child protection

- **Lack of MH services**
  - MH services are minimal and hard to access
  - MH services (lack of availability and affordability) **X X X X**
  - Lack of MH services, especially substance abuse **X X X**
  - Lack of substance abuse services for youth **X X**
  - Drug addiction and treatment of that addiction
  - Meth problems
  - Length of time it takes to get MH assessments for kids
  - MH system is difficult to navigate
  - Substance abuse **X X X**
  - Access to substance abuse treatment

- **Lack of Resources**
  - Lack of expertise in infant abuse
  - Lack of good foster parents who can deal with tough kids
  - Lack of after hours day care
  - Lack of therapeutic resources
  - Lack of Day Care funding **X X X**
  - Lack of Foster Care resources
  - Lack of Transportation to services
  - No funds for Transportation and school nurses
  - Funding sources for new programs
  - Funding sources for needy families
  - Lack of jobs, poverty

Barriers to child protections continued.……..

- Workload is continuing to increase
- Lack of parental cooperation with DSS case plans
- Parents' ability to work towards case plan
- Public Awareness of mandatory reporting laws
- Inability to prosecute offenders of young children in SA cases
- Geographically close to three state lines---families move
- Low pay for CPS workers
- Turnover of social workers
- Cost of Drug Screens prohibitive for some parents
- Domestic violence X X

- Drug use
- Judicial system
- Decent affordable housing
- Inadequate state laws relative to victim rights
- Language and Social barriers

Attachment III

Individual Team Accomplishments

Burke Successful in aiding DSS with some tough case decisions.
Successfully brought ER Doctors in line with reporting abuse protocols.

Caldwell Positive responses from local HD and DSS Boards and County Commissioners.
Currently working on a local poster campaign around young mothers bonding with their babies.

Clay Education of community, abuse, neglect, lack of local placements. Education of team on MRS approach.

Henderson Coordinated with Kiwanis Club to promote Shaken baby syndrome Awareness
Program via distribution of pamphlets to local citizens, hospitals and clinics. Worked in
Conjunction with the United Agenda for Children composed of 40 non-profit agencies that gathered
Citizens from all over the county to weigh in with their concerns about county children. Over 280 residents spent a full day at the High School to arrive at key goals to which a continuing task force will respond and measure success of achievements in the area of education, health and safety. Promoted inter-agency communication and community dialogue with Mainstay. Began a review of timely mental health intervention methods and providers.

Jackson Helped develop a new program for early intervention in domestic violence, prior to adjudication, along with the local DV center and other county partners.

Lincoln Established a safe teen committee, re-worked our community standards.

Macon Increased community education about the problems of child abuse and neglect in our county.

McDowell no information listed

Madison CCPT was instrumental in supporting CPS workers for a much needed salary adjustment. Madison has become a "feeder" county to neighboring DSS agencies who hired recently trained workers at salaries outside the range of Madison.

CCPT would like to retain good workers and maintain their longevity with the agency.

Mitchell — Plan to launch a public awareness campaign on child abuse and neglect.

Polk — As a result of the needs outlined in the team's Annual Report to the County Commissioners, the commissioners agreed to provide a community service assistant to the DSS staff, as well as providing extended space to increase the Juvenile worker from part time to full time.

Rutherford — Formed a Domestic Violence work group to address needs in the community. Began a public awareness campaign for the Safe Surrender Law. Delegated a member to work with the hospital and other medical providers in securing additional training in child abuse involving infants and children.

Accomplishments continued

Swain — More community participation and regular attendance of the team members.

Transylvania — DSS was given a doll that can be used with parents to demonstrate what happens in the brain when a baby is shaken. Educational packets were put together and are used in the community. Hospital put in a tracking system so that their employees in ER can track visits of children. Partnered with child advocacy center to do community awareness during child abuse prevention months and had a diaper drive as part of this effort.

Yancy — working all year on the Hispanic culture, how to work with the people, whom they do and do not trust, strengths, fears, etc. Education.

<u>Public Awareness Campaigns launched or supported by the local CCPT in any of these areas:</u>

Reporting child maltreatment X X

Recruiting foster and adoptive parents X X X

Informing the county about the Sate Surrender Law X X X X X

Parenting education topics X X

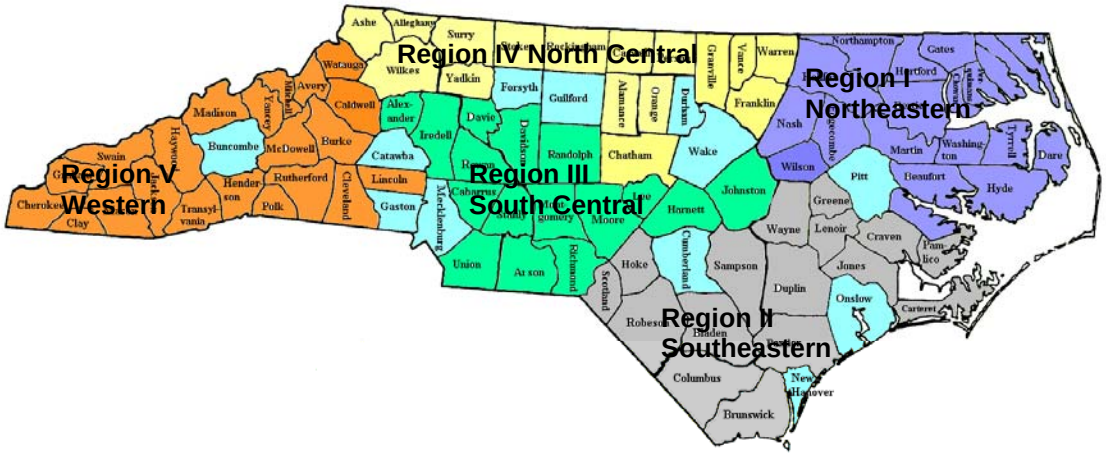
Multiple Response System X

Recruiting CCPT members X

Region 6 A: Urban Region –Western-Central

Buncombe
Gaston
Mecklenburg
Catawba
Forsyth
Guilford

Regional Community Child Protection Team



CCPT Regional End of Year Report Format

Region VI A

MEMBERS PARTICIPATING IN DEVELOPING THE REPORT

Pamela Brooks, Carol McConnell, Lisa Alexander, Lenora Campbell, Cynthia Napoleon-Hanger, Cathie Beatty, Sally Bradshaw

BRIEF OVERVIEW OF CHILD WELFARE WITHIN THE REGION

The VI-A regional CCPT Team met with Phyllis Fulton in February 2008 to begin plans for the Regional End of Year report and to establish the Regional Team and Community Partnerships. End of Year reports were submitted by each county and a review took place to identify themes and make recommendations to the State CCPT team.

Each of the six counties identified as VI-A have local CCPT teams and much work has taken place within the local areas.

Catawba County's team focused on education for team members on issues such as:
Hispanic growth in community and challenges for CPS interventions
Concern about trend of infant fatalities as a result of accidental suffocation
New challenges of Federal Reviews, increased mandates, and no increase in resources
Our primary project has involved a study of safe sleep for infants with the development of a community campaign involving distribution of educational materials, education in the hospital birthing centers, etc.

RECOMMENDATIONS

1. State of need or problem.
   1. Mental Health Issues/Substance Abuse/Domestic Violence
   Lack of affordable services and access to services

   A. Objective/Outcome
      1. Improve access to services that are affordable and effective
      2. Measurable outcomes
   B. Recommendation
      - Examine Catawba County model-integrating the MH/SA/DV
      - More effective LME's
      - County Identification of services, barriers
      - Look at effective models already in place
      - Research and model (Catawba Co.)

2. State of need or problem
    1. Lack of all levels of foster care (regular to therapeutic)

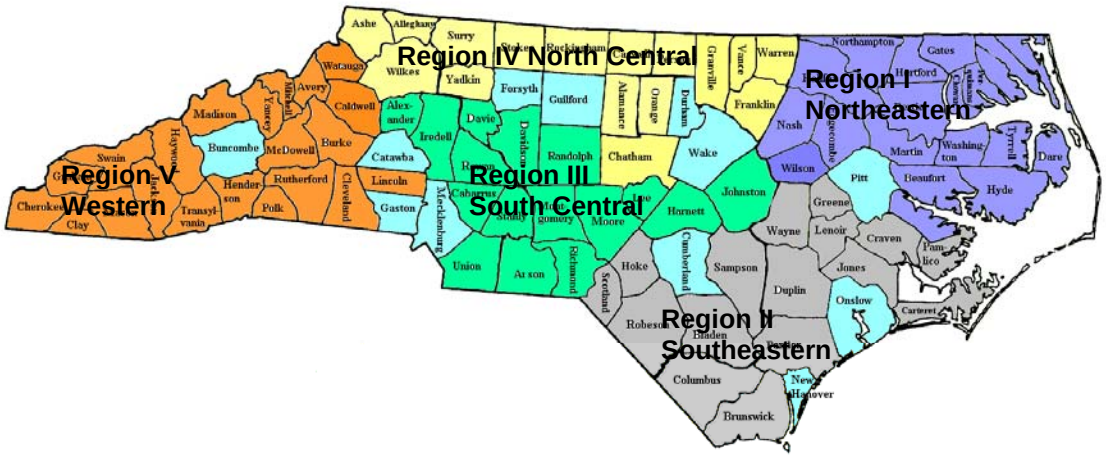
        A. Objective/Outcome
            1. Improve access to appropriate out-of-home placement
        B. Recommendation
            - Increase efforts to recruit, train, and support caregivers who have ability and skills with increased funding from the state
            - Fund supportive services for kinship care at a level that enhances ability to provide quality care and permanency

3. State of need or problem
    1. Lack of access to affordable daycare for low to middle income families
        A. Objective/Outcome
            1. Identify available local, state, federal funding resources
            2. Families access to available, safe, affordable (24-7), traditional and non-traditional daycare services
        B. Recommendation
            - State/Identify available daycare
            - Increase funding
            - Partner with local chamber of commerce and industrial development commission, employers, county agencies to develop a plan to address gaps

Region 6 B : Urban Region: Central- Eastern

Cumberland
Durham
Wake
Pitt
Onslow
New Hanover

Regional Community Child Protection Team



CCPT Regional End of Year Report Format

REGION VIB

MEMBERS PARTICIPATING IN DEVELOPING THE REPORT

Heather Skeens (Cumberland), Loretta Keelin (Onslow County), Katie Lemaire (Parenting Education Empathy Rapport and Support {PEERS}), Julie Rawls (Pitt), Joan Dramis (Wake, Liz Kachris-Jones (New Hanover GAL), Gina Bustle (Safe Child)

BRIEF OVERVIEW OF CHILD WELFARE WITHIN THE REGION/STATE

Child welfare within the VIB region is diverse. The counties are spread across the state and had to be separated from the rest of the region due to logistics for meeting purposes. In region VIB, there are two counties with military bases, and four counties with large regional hospitals. One of the counties has the largest 0-5 year old population in the state, which is the most at risk population.

All of the counties currently utilize MRS in some capacity and have an active CCPT. The county meetings for CCPT vary from monthly to quarterly.

SPECIFIC TEAM ACCOMPLISHMENTS DURING 2007

Public awareness was made a priority with communities displaying safe surrender and shaken baby posters and educating the public on these subjects. Articles on the purpose of CCPT were also written to educate the community. Activities throughout counties varied. One CCPT received a grant to place billboards in the community to increase knowledge of the public agencies who work with children who are maltreated. They also increased community awareness to include the Period of Purple Crying and Darkness to Light education and held a forum called "Too Young to Die" focusing on child fatalities and how to prevent them and to develop investigations and preserve evidence for criminal prosecution. Another CCPT worked with their community hospital to create a position on their staff for a child abuse prevention specialist. One CCPT developed protocols with the emergency room of the hospital for reporting child maltreatment. Another CCPT had a consumer join the team

RECOMMENDATIONS

1. **Statement of need or problem:**

   Inconsistent application of best practice principles across the state by agencies, public and private, that work with children and families including, but not limited to, the Department of Social Services, the Mental Health System, School System, day care, and Department of Defense

Objective/Outcome:

All staff will adhere to a consistent application of best practice principles to ensure that quality service delivery will be offered to children and families.

Recommendations:

1. Education of new and current Child Welfare staff on the Child and Family Services Review

2, Develop and follow the MOU/MOAs established with the Department of Social Services, Law Enforcement, Department of Defense, Mental Health, local school system for consistent collaboration.

3. Training and review of any updates should be disseminated to all agencies and their staff. Each agency will be responsible for notifying CCPT of updates or changes to best practice policy.

4. Counties must have a method of notifying all agencies with contact numbers for after hours personnel and phone numbers, when they provide after hours services. This information must be kept current.

2. Statement of need or problem:

1. All professionals to include medical personnel should be trained on recognizing and reporting child abuse and neglect.
2. There is currently insufficient training and funding for medical professionals serving children in identifying and treating in child maltreatment

Objective/Outcome:

1. All professionals should have training available in their community available to them on how to identify child maltreatment.
2. Medical personnel should have regular trainings available to them on issues of child maltreatment.

Recommendations:

1. Funding and partnering with other agencies (Prevent Child Abuse) for trainings and seminars locally for medical personnel to increase knowledge of child maltreatment.
2. CCPT will help disseminate training information on such trainings.

3. Encourage incentives for physicians who participate in the Child Medical Examiners program for both the initial and ongoing training.

3. Statement of need or problem:

The Mental Health system is difficult to understand and access.

Objective/Outcome:

To have consistent and quality mental health services available to all citizens in North Carolina.

Recommendation

1. Oversight and report on the quality and services provided to the community, i.e. a Report Card on the mental health system.
2. Credentialed substance abuse professionals willing to provide outpatient treatment.
3. Insure funding for outpatient and inpatient treatment for women with children who have a substance abuse problem.
4. Increase availability of home based treatment services that are aware of child maltreatment, MH/DD/SAS.

4. Statement of need or problem:

Parents are in need of ongoing education and training of child development and parenting techniques.

Objective/Outcome:

Parents should have access to inexpensive or free training or educational seminars to assist them in various parenting techniques and areas of child development.

Recommendations:

1. Early childhood education seminars to cover issues such as:
   Shaken Baby (Period of Purple Crying)
   Back to Sleep-this includes co-sleeping
   Proper car seat placement
   Safe child
   Fire code law

2. Parenting education programs for all ages of children to help parents learn alternative parenting techniques.
3. Provide for educational programs on chronic medical conditions for those outside of the medical field working with families to ensure proper understanding of the needs of the family.

5. Statement of need or problem:

1. There is an inability for families to access services if they are undocumented residents.
2. The lack of availability of quality day care for families.

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Objective/Outcome:

That families know how to access and receive services to enhance their quality of living.

Recommendation

1. Increase the funding for quality, affordable daycare throughout the state and decrease or eliminate a waiting list.
2. To fund programs that would assist undocumented aliens in enhancing their quality of living.

Appendix B

Regional CCPT Structure by County

Region 1- Northeastern

Beaufort	Hyde
Bertie	Martin
Camden	Nash
Chowan	Northampton
Currituck	Pasquotank
Dare	Perquimans
Edgecombe	Tyrell
Gates	Washington
Halifax	Wilson
Hertford	

Region 2- Southeastern

Bladen	Jones
Brunswick	Lenoir
Columbus	Pamlico
Carteret	Pender
Craven	Robeson
Duplin	Sampson
Greene	Scotland
Hoke	Wayne

Region III - South Central

Alexander	Lee
Anson	Montgomery
Cabarrus	Moore
Davidson	Randolph
Davie	Richmond
Harnett	Rowan
Iredell	Stanly
Johnston	Union

Region IV- North Central

Alamance	Person
Alleghany	Rockingham
Ashe	Stokes
Caswell	Surry
Chatham	Vance
Franklin	Warren
Granville	Wilkes
Orange	Yadkin

Region V- Western

Avery	Haywood	Mitchell
Burke	Henderson	Polk
Caldwell	Jackson	Rutherford
Cherokee	Lincoln	Swain
Clay	Macon	Transylvania
Cleveland	Madison	Watauga,
Graham	McDowell	Yancey

Region VI A- Western and South Central Urban

Buncombe	Gaston
Catawba	Guilford
Forsyth	Mecklenburg

Region VI-B – North Central and Eastern Urban

Cumberland	Pitt
Durham	Onslow
Wake	New Hanover

Appendix C

Regional Community Child Protection Teams Membership

Region I Team Composition

1. Andrew Payne- Wilson County DSS
2. Carol Cobb- Edgecombe County Public Schools
3. Christy Nash- Wilson County DSS
4. Debbie Cook- Nash County DSS
5. Eva Rogers- Nash County Guardian Ad Litem
6. Gloria Braddy- Bertie County DSS
7. James Yates- Chowan County Citizen
8. Jeff Mitchell- Dare County Emergency Medical Services
9. Kay Overton- Washington County Partnership for Children, Inc.
10. Linda Roberts- Mid-East Commission, Beaufort County
11. Mary Jo VanHorne- Franklin County Guardian Ad Litem
12. Melissa Ferrell- Currituck County DSS
13. Michele Braswell- Halifax County DSS (Co-Leader)
14. Pandora College- Citizen and GAL- Tyrell County
15. Sarah Lane- Camden County DSS
16. Susan Davenport- Martin County DSS
17. Terry Bell- Northampton County Guardian Ad Litem (Team Leader)
18. Midge Hudyma- Elizabeth City/Pasquotank Schools (Recorder)
19. JoAnn Jordan- Bertie County Health Dept.
20. Rev. Gregory Gilliam- Faith Community
21. Stephanie Bradley- Currituck County DSS
22. Delphine Wiggins- Edgecombe County DSS
23. Brenda Brown- Herftord County DSS
24. Kathy Ford- Pasquotank County DSS
25. Edie Armstrong- Tyrrell County School Social Worker- JCPC Coordinator
26. Felicia Gregory- Franklin-Vance-Warren Opportunity, INC.
27. Jeff Woodard- Warren County DSS
28. Constance Green- Warren County Citizen
29. Karen Ross- MTW Health Dept.
30. Amy LaTour- Wilson County DSS

Region II Team Composition

1. Jackie Dennis- Bladen County Health Department
2. Alyson Nowicki- The Carousel Center
3. Melinda Lane- Columbus County DSS
4. Gretta Hill- Craven County DSS (Team Leader)
5. Tracy Jones- Duplin County DSS
6. Debra Jones- Greene County DSS
7. Beth Byrd- Harnett County DSS
8. Thelma Simmons- Jones County DSS
9. Sara Messer- Lee County Schools (Co-Leader)
10. Monica Williams- Lenoir County DSS
11. Deloris Burch- Lenoir County DSS

12. Janice Weigand- Pamlico County Citizen
13. Sandra Evens- Pamlico County Citizen
14. Mary Margaret Hobbs- Sampson County DSS
15. Nancy Williams- Tri-County Community Health Center
16. Thomas French- Scotland County Citizen
17. Colleen Kosinski- Wayne County Guardian Ad Litem

Region III Team Composition

1. Anne Laukatitis-Cabarrus County Partnership for Children
2. Cindy Hendricks- Domestic Violence Services in Davie County
3. Wilma Laney- Moore County DSS Board Member
4. Kathy Hitchcock- Davidson County DSS
5. Mary O'Neal Mauney- Union County DSS
6. Sharon Scott- Stanly County DSS
7. Elizabeth Blair- Rowan County Citizen
8. Alice Lammonds- Montgomery County DSS
9. Leeanne Whisnant- Alexander County Health Dept.
10. Vickey Gilmore- Anson County DSS
11. Mary Kendall- Anson County DSS
12. Connie Polk- Cabarrus County DSS
13. Melissa Hill- Davie County DSS
14. Krista Shaw- Montgomery County DSS
15. Barrett Hollimon- Richmond County DSS
16. Tom Naper- Union County DSS

Region IV Team Composition

1. Robin Testerman-Children's Center of Surry (Co-Leader)
2. Linda Devine- Stokes County Guardian Ad Litem (Co-Leader)
3. Betty McGurk- Surry County Citizen
4. Amanda Reeves- Rockingham County Guardian Ad Litem
5. Joan Corio- Children's Center of Surry
6. Nanci Shannon- Ashe County Schools
7. Diane Rocker-Orange County Schools
8. Carmen Coley- Child Victim Services of Chatham County
9. Tim Murphy-Wilks Coounty Child Abuse Prevention Team
10. Hillary Carroll- Burlington Pediatrill
11. Callie McBroom- Alamance County DSS
12. George Bryant- The Children's Home
13. Ken Richardson
14. Tonia Goad
15. Erin Eskridge
16. Tammy Chaney
17. Cathy Waugh
18. Lee Cornett
19. Hillary Carroll

Region V Team Composition

1. Alisa Ashe- Macon County KIDS Place
2. Cathy Brooks-Polk and Rutherford County Smart Start (Team Leader)
3. Vanessa Henley- Avery County
4. Kelly Icenhour- Avery County DSS
5. John Lewis- Madison County Guardian Ad Litem
6. Lou Parton- Polk County DSS
7. Kathie Williams- The Children's Center of Transylvania County
8. Chris Jernigan- South Mountain Children's
9. Donna Crawford- Cherokee County DSS
10. Dawn Wilde- Clay County Citizen
11. Theresa Waldroup- Clay County Citizen
12. Kristy Smith- Jackson County DSS
13. Phyllis Bentley- Henderson County Citizen
14. Donna Lupton- Haywood County DSS
15. Allison Best-Teague- Haywood County Citizen
16. Paula Delorenzo- Henderson County Citizen
17. Kris Edwards- McDowell County
18. Hazel Yelton- Mitchell County
19. Larry Deyton- Mitchell County DSS
20. Susan Grider- The Family Place/ Citizen of Transylvania

Region VI-A Team Composition

1. Pamela Brooks- Catawba County DSS
2. Carol McConnell- Catawba Citizen/Parent (Co-Leader)
3. Lisa Alexander- Guilford County Health Dept.
4. Lenora Campbell- Citizen/ WSSU Grandparenting Program (Co-Leader)
5. Cynthia Napoleon-Hanger- N.C. Exchange/SCAN Citizen
6. Cathie Beatty- Buncombe County DSS
7. Sally Bradshaw
8. George Bryan- The Children's Home
9. Evan Friedel- NC DSS (Citizen representative)

Region VI-B Team Composition

1. Heather Skeens- Cumberland County DSS (Co-Leader)
2. Loretta Keelin- Onslow County DSS (Co-Leader)
3. Katie Lemaire- New Hanover Citizen/ Consumer
4. Julie Rawls- Pitt County DSS
5. Joan Dramis- Wake County Human Services –RN, Review Coordinator
6. Liz Kachris-Jones- New Hanover Guardian Ad Litem
7. Ginna Bustle- Safe Child
8. Gail Angle- Durham County DSS
9. Mary Ann Atkins- New Hanover and Pender District Attorney's Office
10. Jim Cox- Pediatric Case Management Program, Pitt Co. Memorial Hospital

Appendix D
North Carolina Child Fatality Prevention State Team Membership
2007-2008

Chair

John Butts, MD
Chief Medical Examiner
NC Department of Health and Human Services

Deborah Radisch, MD, MPH (designee)
Associate Chief Medical Examiner
Child Fatality Prevention Team Director
NC Department of Health and Human Services

Members

Selena Childs
Executive Director
NC Child Fatality Task Force

Sarah Currier
Program Consultant
Prevent Child Abuse NC

Keith Davis
Local Support Operations Manager
Division of Social Services
NC Department of Health and Human Services

Al Deitch*
Executive Director
Youth Advocacy & Involvement Office
NC Department of Administration

Mike East
Assistant Special Agent in Charge – Capital District
North Carolina State Bureau of Investigation

Brenda Edwards*
Child Fatality Local Teams Coordinator
Division of Public Health
NC Department of Health and Human Services

Anita Evans
Child Fatality Reviewer
Division of Social Services
NC Department of Health and Human Services

Phyllis Fulton
Community Child Protection Teams Coordinator
Division of Social Services
NC Department of Health and Human Services

Gloria Hale
EMSC Program Manager
Office of Emergency Medical Services
NC Department of Health and Human Services

Catherine Joyner*
Executive Director of Child Maltreatment Prevention
Division of Public Health
NC Department of Health and Human Services

Gerri Mattson, MD
Pediatric Medical Consultant
Children & Youth Branch
NC Department of Health and Human Services

Faye McDaniel
Education Consultant
NC Department of Public Instruction

Susan E. Robinson*
Program Manager
Office of Prevention & Early Intervention
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services
NC Department of Health & Human Services

Angenette Stephenson
Assistant Attorney General
Office of the Attorney General
State of North Carolina

Jane Volland
Administrator
Guardian Ad Litem Program
NC Administrative Office of the Courts

John Weil
Child Fatality Reviewer
Division of Social Services
NC Department of Health and Human Services

* Member of the Subcommittee responsible for the development of the 2007 Annual Report

Appendix D
NC-DSS Policy on Community Child Protection Teams[1]

Community Child Protection Teams are avenues for communities to participate in child protection. The Division will support Community Child Protection Teams as they accept the task of protecting children.

I. Authority

Community Child Protection Teams (CCPT) were established as one means for the state and local communities to form a partnership to strengthen child protection. CCPTs were established in response to Executive Order 142 in May of 1991. The duties and responsibilities of the CCPT were adopted as North Carolina Administrative Code 41I .0400. The original purpose and composition of the team was further formalized and expanded by G.S. 7B 1406, effective July 1, 1993.

II. Nature and Purpose of the Community Child Protection Team G.S. 7B 1407

A. The Community Child Protection Team is an interdisciplinary group of community representatives who meet regularly to promote a community-wide approach to the problem of child abuse and neglect. The Community Child Protection Team is not a Department of Social Services team.

A. The Community Child Protection Team may not encompass a geographic nor governmental area larger than one county.

III. Composition of the Community Child Protection Team (G.S. 7B 1407)

The Community Child Protection Team shall consist of representatives of public and nonpublic agencies in the community that provide services to children and their families and other individuals who represent the diversity of the community. Membership is mandated by law and includes:

A. The **county director of social services** and a member of the director's staff;

B. A **local law enforcement officer**, appointed by the board of county commissioners;

C. An **attorney** from the district attorney's office, appointed by the district attorney;

D. The **executive director of the local community action agency**, as defined by the Division of Economic Opportunity, Department Health and Human Services, or the executive director's designee;

[1] Provided by NC-DSS

E. The **superintendent of each local school administrative unit** located in the county, or the superintendent's designee;

F. A **member of the county board of social services**, appointed by the chair of that board;

G. A local **mental health professional**, appointed by the director of the area authority established under Chapter 122C of the General Statutes;

H. The local **guardian ad litem coordinator**, or the coordinator's designee;

I. The **director of the department of public** health; and

J. A local **health care provider**, appointed by the local board of public health.

The board of county commissioners may appoint a maximum of five additional members to represent various county agencies or the community at large to serve on any local team. Team members appointed by the board of county commissioners should represent the diversity of the community. This is an opportunity for teams to involve all entities of the community that that impact children or have the potential to impact children.

Teams may appoint an advisory committee to augment the team process. This committee may be composed of individuals that represent county entities that have child well being as a focus but are not included in the mandated composition of the CCPT. The advisory committee may serve at the CCPT's pleasure in whatever capacity the CCPT deems necessary. It is important that all members of the CCPT feel a part of the team as the team pursues its purpose of protecting children.

When a mandated team member is by law a member of the CCPT in more than one county, that member is encouraged to select a designee who resides in the county where the team is located. This action will insure that local CCPT members have a vested interest in advancing child protection based on the needs of children and families in their county.

The original appointing authority shall fill vacancies.

A list of CCPT members should be forwarded to the Division in January of each year. The list should include the mailing address, telephone number, and agency or group affiliation of each member.

IV. Duties and Responsibilities of the Chair [G.S. 7B 1407]

A. Each local team shall elect a member to serve as chair at the Team's pleasure. The chair shall schedule meetings, including time and place, and shall prepare an agenda.

B. The chair should be an individual who is a proven leader is willing to dedicate ample time and energy toward team maintenance.

B. The chair shall participate in training developed by the Division of Social Services. Such training shall address the role and function of the child protection team, confidentiality requirements, an overview of CPS law and policy, and team record keeping. The Division of Social shall be notified when a new chair is elected.

V. Duties of the County Director of Social Services (G.S. 7B 1409)

The Community Child Protection Team is a community team**. The team is not a department of social services team**. The Division will channel Community Child Protection Team business and information through the Community Child Protection Team chair and the county director as a means of continuity. To augment the Community Child Protection Team process the county director shall perform the following duties:

A. Assure the development of a CCPT handbook to include the composition of membership, frequency of meetings, confidentiality policies, training of members, and duties and responsibilities of members.

Additional areas which may be addressed in the operating procedures include, but are not limited to: terms of membership, absenteeism, substitution of agency representatives, expectations for decision-making and recommendations, procedures for follow-up, identification of a media spokesperson, and procedures for bringing non-DSS cases for review. **The team may also establish parameters for responding to community requests that expand the team role beyond that which is legislated.** The director shall ensure that all procedures are updated by the team as needed, reflecting changes in policy and law.

B. Assure that the Team defines the categories of cases that are subject to its review;

C. Determine and initiate cases for review;

D. Bring for review any case requested by a Team member;

E. Provide staff support for these reviews;

F. Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Team, and signed confidentiality statements required under G.S. 7B 1413, in compliance with applicable rules and law; and

G. Report quarterly to the county board of social services, or as required by the board, on the activities of the Team.

VI. Responsibility for Training Team Members (G.S. 7B 1411)

The Division of Social Services, Department Health and Human Services, is required by statute to develop training and make available on an ongoing basis a CCPT operational handbook, confidentiality requirements, overview of child protective services law and policy, and team record keeping.

Teams are encouraged to integrate training into the structure of the team meetings on an ongoing basis. Such training may be offered by the county CPS unit staff or supervisors, the Children's Programs Representatives from the Division of Social Services, the child welfare attorneys, other staff from the Children's Services Section, and experts from the community and the Division's CCPT Coordinator. Cooperative training, sponsored by teams for other counties as well as their own team membership, is also encouraged.

VII. Frequency of Meetings [G.S. 7B 1407]

Community child protection team meetings shall be scheduled with sufficient frequency to review defined cases, but must meet at least quarterly. In deciding the frequency of team meetings, it is important to note that meeting frequency impacts on team effectiveness and participation. Additional meetings may be scheduled in order to review child fatalities in a timely manner.

VIII. Duties and Responsibilities of the Community Child Protection Team G.S. 7B 1406

A. Review active cases in which abuse, neglect, or dependency is found and that are:

1. Selected from categories defined by the team;

2. Brought for review at the specific request of a team member; or

3. Brought for review at the initiative of the director of the department of social services.

Federal and State laws require that a citizen review panel be in place to review certain cases receiving child welfare services. In North Carolina CCPT has been designated as the ***citizen review panel***.

B. The purpose of reviews shall be to:

1. identify whether gaps and deficiencies exist within the community child protection system which have impact on the incidence of abuse, neglect, or dependency or on the child fatality;

2. increase public awareness about conditions that impact on child protection within the community;

3. advocate for system changes by promoting collaboration between agencies in the creation or improvement of resources for children as a result of their review of selected cases;

4. to use the CCPT to assist the county director in the protection of children living in the family being reviewed;

5. and to inform the county commissioners about actions needed to prevent or ameliorate child abuse, neglect, or dependency.

C. Selection of Cases for Review

Categories of cases reviewed by the team are to be based on local need, but may include one or more of the following groups of children noted in the literature to be at higher risk of subsequent injury or death as a result of child abuse, neglect, or dependency:

1. Substantiated cases of abuse, including sexual abuse (when considering substantiated cases that warrant a CCPT review it is recommended that the cases selected for review reflect family issues that indicates a gap in services or a need for team collaboration);

2. Reports of neglect of a child, especially when made by a medical provider (specifically reports of maltreatment involving dehydration, bruises, broken bones, positive tests for controlled substances, etc.);

3. Cases in which the department has substantiated two reports within a specific period, regardless of the type of report or referral source;

4. Other cases at the request of a team member, including children receiving child any welfare services, cases known to team members where there are indications that a child has been affected by a deficiency in a community system or resource and

5. Child fatality reviews.

D. Review of Child Fatalities

Each Community Child Protection Team shall review fatalities which are **suspected** to have resulted from child abuse, neglect or dependency; **and**

1. A report of abuse, neglect, or dependency has been made about the child or his family to the county department of social services within the previous twelve months; **or**

2. The child or his family received child protective services within the previous twelve months.

Report to the Board of County Commissioners

G.S. 7B 1406 requires that the team submit an annual report to the board of county commissioners which contains

recommendations, if any, and advocacy for system improvements and needed resources when gaps and deficiencies exist. In January of each year a copy of the report to the Board of County commissioners will be sent the Division.

IX. Family Centered Practice

1. The local Department of Social Services shall inform a family if the Community Child Protection Team selects that family's child welfare case for review. The family will be informed of the purpose of the Team and why the family's case was selected for review.
2. The family may be given an opportunity to meet with the Community Child Protection Team to provide the team with information relevant to the case. The Department of Social Services must provide the family with the Team's contact information, i.e., chairperson's names, and Team logistical information.
3. Within thirty days of the Team's review of a case, the family must be provided with the outcome of the team review.

Advocacy

Some advocacy strategies adopted by teams and recommended for consideration are:

1. Involvement of the media in educating the community about gaps in community services;

2. Utilization of resources represented by members to create services in response to identified gaps;

3. Sharing of information about under-utilized resources in the community which help to address service gaps; and

4. Directing concerns to the board of county commissioners about trends in abuse or neglect that suggest a need for increased or changed services in the community, and advocate for necessary resources to facilitate change.

IX. Records (G.S. 7B 1413)

A. **Meetings of the community child protection team are no longer subject to the provisions of the Open Meetings Law (G.S. 143-318.10).** However, local teams may hold periodic public meetings to discuss in a general manner not revealing confidential information about children and families, the findings of their reviews and their recommendations for preventative actions. Minutes of all public meetings, excluding those of

executive sessions, shall be kept in compliance with Article 33C of Chapter 143 of the General Statutes. These minutes shall be permanent public records and shall be maintained according to the standard administrative record retention schedule.

B. Information regarding individual clients shall be discussed in **executive session**. If any minutes are generated in the executive session, they shall be sealed from public inspection.

C. Local teams **shall** have access to all ***medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of the law, including police investigations data, medical examiner investigative data, health records, mental health records, and social services records.*** The team may not, as part of the reviews authorize by law, contact, question, or interview the child, the parent of the child, or any other family member of the child whose record is being reviewed. It is recommended in the support of best practice and family centered services, that a family be informed that the child's case is being reviewed by CCPT. Cases receiving child protective services at the time of review shall document the CCPT review as well as CCPT **recommendations.** Additional documentation shall be at the discretion of the director of the county department of social services.

D. The county director shall maintain lists of participants for each team meeting and confidentiality statements signed by team members and invited participants. Such records shall be maintained by the standard administrative record retention schedule.

X. Confidentiality (G.S. 108A-80; G.S. 7B 1413)

G.S. 108A-80 states that unless specifically excepted, "it shall be unlawful for any person to obtain, disclose or use, or to authorize, permit, or acquiesce in the use of any list of names or other information concerning persons . . . receiving . . . social services that may be directly or indirectly derived from the records, files, or communications of the Department or the county boards of social services, or county departments of social services or acquired in the course of performing official duties pursuant to NCAC 41I. . . ." Additionally, case records of juveniles under protective custody of the department of social services or under placement of the court are protected as confidential under G.S. 7B-2901. Breach of confidentiality is a misdemeanor offense.

A. Confidential information and records acquired or created by the Community Child Protection Team in the exercise of its duties are not subject to discovery or introduction into evidence in any proceedings and may only be disclosed as necessary to carry out the purposes of the team.

B. No member of the Community Child Protection Team, nor any person attending a meeting of the team, may testify in any proceeding about what

transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meetings. This does not prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

C. The county director is authorized to share with the community child protection team any information available to him that is needed by the team members in the execution of their duties. In reviewing non-fatality cases CCPT shall have access to all medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of CCPT, including police investigation data, medical examiner investigative data, health records, mental health and social services records.

The federal Family Educational Rights and Privacy Act (FERPA), which is commonly known as the "Buckley Bill", limits with certain exceptions, the disclosure of information contained in public school records. One such exception pertinent to the purposes of a CCPT in reviewing non-fatality cases is when the health and safety of the student is in question. Thus, a public school whose student is the subject of an active protective services case may respond to an inquiry from the Department of Social Services.

Information from alcohol and drug treatment programs is protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The individual receiving these alcohol or drug treatment services must give written consent on the federal Consent for the Release of Confidential Information form. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. To obtain information from alcohol and substance abuse records without written consent from the patient CCPT must obtain a court order after a special hearing.

D. Each team member and invited participant shall sign a statement indicating their understanding of and adherence to confidentiality requirements including possible civil and criminal consequences of any breach of confidentiality. Rules regarding confidentiality shall apply to any personal files that are created or maintained by any team member or invited participant.

E. **Team members <u>are</u> permitted to share with their respective agencies, on a need-to-know basis, information acquired at a community child protection team meeting regarding a current client or referred case.**

F. Members of the team who have access to client information and fail to comply with the rules of confidentiality shall be denied access to confidential information and are subject to dismissal from the team.

G. Any invited participant who is given access to client information during the team review and fails to comply with the rules of confidentiality shall be denied participation in further team reviews.

H. **The county director shall not share any information that discloses the identity of individuals who have reported suspected abuse, neglect, or dependency to the department of social services.**

I. **Family Centered Practice charges service providers with the responsibility of insuring that the family's right to participate in all facets of the case is respected. Informing families about CCPT and that CCPT will review a child's record is in keeping with the concept of Family Centered Practice.**

J. Minutes of the general session shall not contain case specific information.

XI. Liability of Team Members

Team members have no responsibility for case decisions or service provision, as their role is advisory. Therefore, it is the opinion of the Attorney General that they as individuals, or as a group, would not have liability in a child protective services case.

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